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Local Evaluation of Morecambe Bay PACS Vanguard

12 Month Report

31/10/2017



Health and Social Care Evaluations (HASCE)



This report has been commissioned by Bay Health and Care Partners, through NHS England Vanguard funding. The report has been produced by Health and Social Care Evaluations (HASCE) at the University of Cumbria.

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Executive Summary

Introduction

This report discusses the findings from the first 12 months of the Health and Social Care Evaluation (HASCE) project to evaluate the New Care Model (NCM) programme delivered by Morecambe Bay PACS Vanguard, Better Care Together (BCT).

This evaluation, commissioned by the Bay Health and Care Partners, sets out to answer specific questions set by the national New Care Models Team (NCMT). It does this via qualitative data collection and analysis on programme processes and outcomes and a health economics evaluation of resource use and outcome, triangulated with quantitative data provided by University Hospitals Morecambe Bay Trust (UHMBT) Business Intelligence team.

The ambition of the NCM requires a more nuanced approach to cause and effect than simple measures of frequency and correlation, as these would be unlikely to capture the specific kinds of change, and the incremental progress this may involve. Consequently, this evaluation is based on a realist approach. This approach assumes that physical and social systems are ordered, yet infinitely complex. Realist evaluation analyses programmes and intervention in terms of their contexts, mechanisms and outcomes. This produces testable hypotheses on who a programme works for, in what context, and why; as part of an ongoing cycle of evaluation.

There were a number of challenges concerning the delivery of BCT itself and how this related to the possibilities of its evaluation. The lack of clear and consistent criteria for 'what success looks like', the size and shape of particular interventions, where BCT 'begins' and 'ends' in terms of inclusion of activities, and identifying the specific contribution of vanguard resources to existing interventions in relation to other funding sources were all identified as problems for the evaluators to overcome.

Findings

BCT is being implemented in a complex context. Based on the data collected for this evaluation, the following points highlight the most prominent affective aspects of this, which have a direct bearing on the outcomes and impact of the work of the NCM:

- Geographical, demographic, historical and organisational features are interacting with the availability of resources to both enable and disable the programme.
- The geographical location and distance between services was also identified as affecting staff retention and recruitment. High staff turnover rates and recruitment difficulties were reported for a variety of roles and participants expressed frustration about the lack of capacity in care teams to implement the NCM. This problem re-emerges later in the process with regards staff attrition.
- Attitudes towards the NCM and engagement with it were affected by perceptions and experiences of previous interventions.
- Organisational cultures emerged as another important contextual factor, as well as the availability of resources.

Overall, the findings suggest that the most positive accounts of change taking place within the NCM are with regard ground-level, localised responses to perceived gaps in services.

Related to this localised activity, participants highlighted the need for 'incremental approaches' to change. It was, however, less clear within the data how these approaches map on to the larger-scale changes in the BCT logic model.

- Participants suggested that current reporting measures were currently not accurately capturing valuable changes occurring at ground level. The methods for gathering localised data are inconsistent, and this risks missing important contextual factors that are key to the success of interventions, and ensuring successful scaling up across the Bay area.

- Changes around improved communication and dialogue between organisations, facilitated by the roles aligned with the vanguard funding, appear to be making important progress in some areas of Morecambe Bay. The main enablers for change were thematised as:
- Successful Multi-Disciplinary Team working.
- Care Navigators and other roles which worked flexibly between the 'gaps' in service provision.
- Where structures were already in place to support partnership working (e.g. commissioning structures allowing sub-contracting), progress was more straightforward.
- Participants consistently referenced improved and more open lines of communication as the main mechanisms for change.

Conversely, the main obstacles to change tended to focus on structural and strategic issues. These were thematised as:

- Short-term funding and project-based approaches to change.
- The length of time many of the changes were taking to implement.
- The length of time that the machinery of BCT was perceived to require.
- Information Governance and Information Technology.
- A perceived lack of support from leadership.
- A lack of a clear sense of what BCT was, and its direction of travel.

Reductions in costs can be shown via reductions in hospital attendance and bed days during the period of vanguard funding. This is based on intermediate data of overall hospital and outpatient activity to evaluate the potential financial impact on the healthcare system.

- While these are a good indicator of overall performance of BCT as a whole and individual ICCs, the link between individual interventions and these metrics is tenuous and, as the target populations of the interventions are small, their effects might not be noticeable on the larger scale metrics.
- The figures presented within this economic analysis represent resource use and associated cost only, in other words, outputs. However, identifying the appropriate data for capturing progress remains a major challenge.
- Qualitative data highlighted a range of non-financial inputs which were key to the delivery of the NCM. Changes in non-financial resource uses were very apparent from participants' interviews, based on localised arrangements around what have been previously perceived to be systemic problems or gaps in service.
- The qualitative data raised an important question regarding the extent to which a return on investment, and the general effectiveness of a programme, will vary depending upon existing assets and skills within a team or area.
- A number of negative themes emerged around the distribution of funding. Certain themes, such as around the commissioning structures themselves, are embedded differences between primary and acute care. Others centre on the transparency of decision-making around funding, the communication of capacity issues to management and the tension between the freedom to develop new ideas at local levels, and a perceived lack of steer or support from middle management up to higher tiers.

The priority for the vanguard was often perceived to be on financial efficiencies, and achieving a reduction in outpatient appointments in particular, rather than the creation of improved patient pathways.

Higher-level metrics report positive trends at certain points within the programme. However, the current structure of data reporting does not allow changes to higher-level metrics to be linked to the changes which BCT has implemented in a methodologically sound way.

- The data suggests that localised successes are not currently being translated into whole-scale change' largely due to the variations in scale of many of the initiatives evaluated, and the low numbers of patients and citizens involved at this stage.
- It is important to note that many of the incremental changes which have been identified by staff were also identified by patient groups as either already taking place, or addressing clear gaps in service. This suggests that many of the qualitative themes around the changes the NCM has introduced have the potential to link up with patient expectations and improve the quality of care.
- While some preventers of positive outcomes link back to contexts outside BCT, participants highlighted several reasons for stakeholders becoming disengaged in the process of delivering the NCM; many of which were linked to the lack of clarity around outcomes, and, related to this, a lack of visible progress.
- This suggests that work on identifying more immediate and incremental outputs and outcomes of the NCM, coupled with a clear sense of how these relate to its larger-scale strategy, may well address many of the preventers which participants reported.
- It is also of note that the outcomes identified in the data reflect a number of outputs and outcomes on the 2016/17 BCT logic model. However, these are not systematic: the data collected and analysed does not identify a number of outputs and outcomes for Year 1-2, whereas some of the longer-term outcomes (3-5 years) are being mentioned. This suggests that the logic model is not featuring at the core of delivery.

Recommendations

The evaluation recommends that improvements can be made in the data reporting, particularly to include addressing gaps raised by the evaluation. This will enable the NCM to demonstrate more robustly the effects of the changes it is delivering. This work would be chiefly around mapping outputs from specific interventions in a clear and systematic way at the planning stage of delivery. This would allow more localised measures (whether quantitative or qualitative) to scaffold up to the higher-level outcomes, and visible change to become apparent earlier within the NCM delivery. This includes:

- Consistent and methodologically robust data collection around incremental change to target populations, with a more consistent approach to mapping inputs for interventions and activities, along with timescales (based on contextualised factors such as existing community assets and relationships), which can then be compared against outcomes.
- Specific data to track for individual interventions on patient level, including input as well as output data which covers enough breadth to measure the impact of the intervention on a patient level.

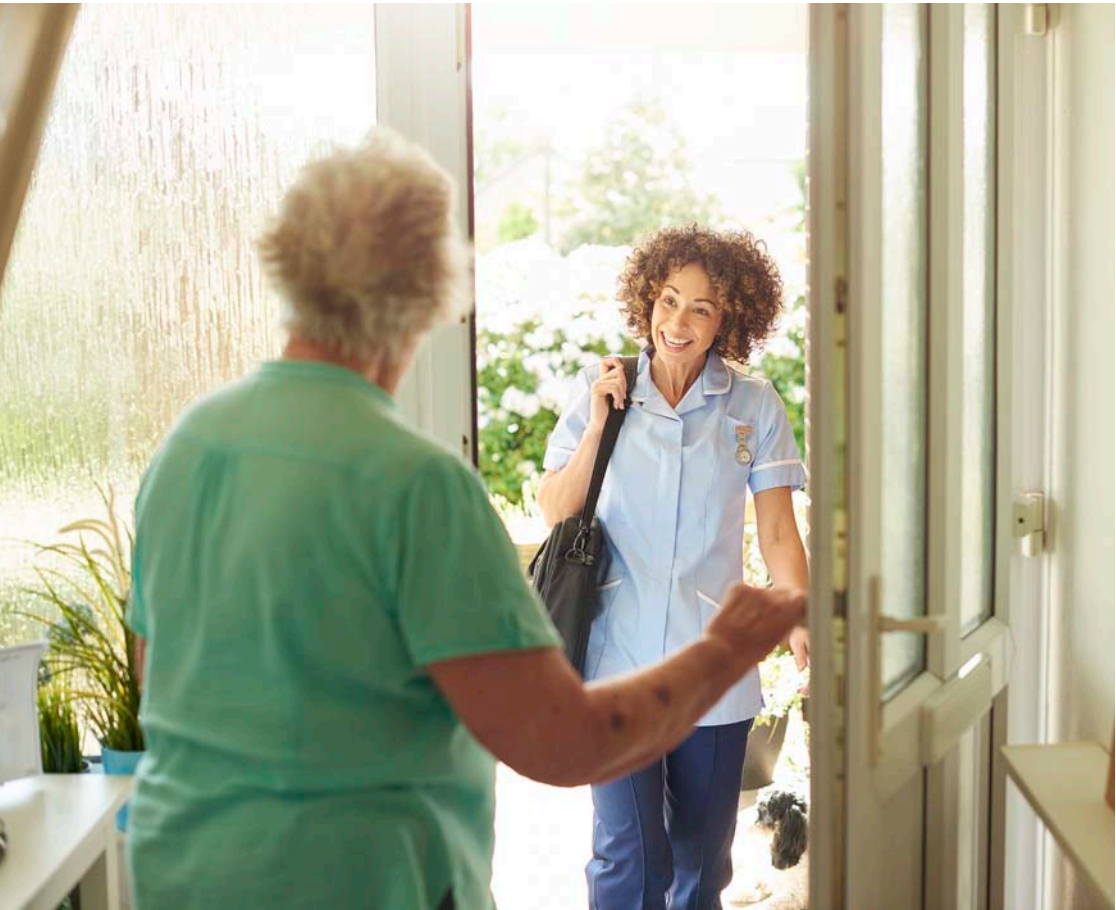
The evaluation recommends that a wider evaluation strategy for the delivery of the NCM is produced to map different elements of data reporting according to strategic criteria for success.

- A recurring theme for participants has been problems with identifying what 'Better Care Together' is, in terms of inclusion/exclusion criteria, measurable outcomes and 'what success looks like'.
- It is important that the outcomes of the programme are clearly aligned to a range of evidence sources, and that outcomes are falsifiable: in other words, that outcomes are able to demonstrate evidence of any lack of success as well as success so that obstacles to delivery can be identified more quickly.

There is a need for the programme to consider the roles of leadership, communication and cultural change in its delivery.

- In order to address the negative themes around these, it is recommended that the programme introduces more transparent 'feedback loops' within its structure.
- Communication across organisations at ground level was reported as one of the key successes of the NCM. There may be some useful learning points and good practice from these successes which can support communication at strategic level.

Following the evaluator's interim report on 18/04/2017, evaluators and commissioners started discussions concerning the next stage of the evaluation and the most beneficial areas to focus on. This led to the identification and recommendation of three specific areas which would inform both the tail-end of the first twelve-month project, and the continuation of the evaluation project across 2017-18. These were the development of Integrated Care Communities (ICCs) in Barrow Town, Bay and East; and the evaluation of a specific intervention within each of these: from the Respiratory pathway (Barrow Town), Paediatrics pathway (Bay) and Frailty pathway (East).



1 Introduction

1.1 Overview

This report discusses the findings from the first 12 months of the Health and Social Care Evaluations (HASCE) project to evaluate the New Care Model (NCM) programme delivered by Morecambe Bay PACS vanguard, Better Care Together (BCT). This evaluation, commissioned by the Bay Health and Care Partners, sets out to answer specific questions set by the national New Care Models Team (NCMT), through qualitative data collection and analysis of programme processes and outcomes, a health economics evaluation of resource use and outcomes, and triangulated with quantitative data provided by University Hospitals of Morecambe Bay Trust (UHMBT) Business Intelligence team. As well as theorising the main successes of the current vanguard programme, this work will support future evaluation by identifying key perceptions, variations and outcomes that can potentially be tracked to evidence the programme’s longer-term impact.

This report provides an analysis and findings of the evaluation work since it began in October 2016, discussion of the emerging responses to the commissioned evaluation questions, and information on how the evaluation will proceed over the next 12 months.

As the Health Foundation rightly note, evaluation is ‘conducted in a spirit of discovery rather than management or monitoring.’¹ This evaluation was commissioned with a specific instruction not to conduct a workstream-by-workstream evaluation, but to gather a picture of changes being made, outcomes affected, successes and obstacles across the whole NCM. This is due to the unique challenge of evaluating the BCT programme, which involves unpacking the complexity of a transformative and evolving programme, requiring collaboration across a range of sectors and wider communities – between NHS organisations, local authorities, the third sector and other local partners, as well as patients and the public.² As such, this is a complex, multi-faceted evaluation which has required iterative development in response to the delivery of the programme itself. This report is not an attempt to map all activities within the vanguard site, but, in response to the NCMT questions, identify the key contexts, changes, outcomes and ‘active ingredients’ at work in the NCM.

1.2 Better Care Together: A Brief Narrative

The BCT programme started in 2012 as a review of health services across Morecambe Bay by Bay Health and Care Partners. This partnership of 11 (now 10, following boundary changes to the two Clinical Commissioning Groups) initiated the review as a response to both the increasing number of challenges for health care provision (including an ageing population, an increase in complex and long-term conditions, and an increased demand on resources), and specific problems within Morecambe Bay Hospitals (including CQC and police investigations). As such, while the focus of these problems tended to fall on the hospitals, some of the root causes of these issues began in primary, community and social care. Furthermore, a number of financial pressures were increased due to the geography of Morecambe Bay, with a dispersed population leading to duplication of services in some areas, and gaps in services in others.

1 The Health Foundation. Evaluation: what to consider. (2015), p.30
2 Foot. C, Gilbert. H, Dunne. P, Jabbal J, Seale B, Goodrich J, Buck D, Taylor J. People in Control of their own Health and Care: the State of Involvement. London: The King’s Fund (2014).
Available at: www.kingsfund.org.uk/publications/people-control-their-own-health-and-care

The BCT strategy document was published in February 2015 by Bay Health and Care Partners, stating:

At the heart of our Strategy is a “population” based approach to promoting wellbeing and providing care in which people and their needs are the focus rather than processes and buildings. Responsibility for health and care will become a true partnership between the people needing to access services and those who provide them.³
The only way that we can guarantee great care within the realities of the budgets available to us is to focus our support and resources on people, not buildings and by providing care as close to home as possible.⁴

Covering, at that time, 2 hospital trusts, 2 Clinical Commissioning Groups, 2 foundation trusts, 2 GP federations , 1 ambulance service and 2 County Authorities, the strategy placed the Triple Aims at its centre as its ‘guiding compass’:

- improving population health;
- improving the individual experience of care;
- reducing per capita health and care spend.

Coinciding with this strategy document, the NHS Five Year Forward View was published in 2014. This presented a wide- ranging strategy plan for NHS England to address the challenges facing NHS over the next 5 years, which include:

- changes in patient health needs (e.g. chronic conditions) and treatment preferences (e.g. greater patient involvement);
- changes in treatment technologies;
- changes in health services and funding structures.

Resonating strongly with the BCT strategy, the Five Year Forward View suggested that if no sustainable strategies are introduced, there will be progressively widening gaps between health and wellbeing, care and quality as well as funding and efficacy. Consequently, the strategy proposed three main pillars for its implementation: establishing new relationships with the patients and communities, introducing of NCMs and implementing innovative models of support strategies.

The Five Year Forward View emphasises the key role of empowering and mobilizing communities in active involvement in the healthcare process: for example, supporting service users in health management via engaging in healthy lifestyles, making informed treatment choices, self- care, education and engagement in health-related community initiatives; as well as increasing the control patients have over the care process, including place, mode and nature of the treatment they receive. These shifts in care are underpinned by improvement of quality and access to the information as well as enhancement of information management systems within and between healthcare settings.

The strategy document identifies this as a gradual process of collective change, involving both NHS organisations and partnerships with the charitable and voluntary sector, as well as community volunteering programs that make contribution to the provision of health and social care. At the same time, the Five Year Forward View recognised that traditional division between primary, secondary, mental health and social services often precludes the provision of personalised and coordinated care. As a result, NCMs were developed to act as a blueprint for the future NHS.

3 The Better Care Together Strategy for the Future for health and care services in Morecambe Bay. (2015) <https://www.uhmb.nhs.uk/files/bct-publications/Better-Care-Together-Plan.pdf> p.6
4 The Better Care Together strategy the future for health and care services in Morecambe Bay (2015), p.11

As part of the NCM programme, in 2015 50 vanguards sites were selected to deliver NCMs through funding from the NHS Transformation Fund. BCT was selected as an Integrated Primary and Acute System (PACS) vanguard, although it included elements of the Multi-Speciality Community Providers (MCPs) model of care. The focus of the PACS model is twofold: to improve primary and acute medicine, and to develop preventative community- based services. The PACS model uses risk stratification and population-based analysis in order to design services tailored to individual needs, and identify groups that need specialised care.⁵ These needs are then addressed through redesigned patient care pathways, patient empowerment, strong collaborative networks with community assets, and redefined workforce roles where appropriate to improve resource deployment and respond to the needs of local communities.

1.3 The Evaluation of Better Care Together: A Brief Narrative

The evaluation approach followed a realist methodology (see below, Chapter 2), and initially planned to spend the first half of the project gathering qualitative data from across the vanguard funded activities. This would provide the evaluation with general hypotheses around the changes and outcomes taking place in the NCM. In the second half of the project, the evaluation would focus in on specific interventions and areas for a more detailed and nuanced account of what was working for who, and why. This would be triangulated with larger-scale data from both the quantitative reporting metrics carried out by UHMBT Business Intelligence, and a large-scale survey conducted across Morecambe Bay by the evaluators.

As Table 1 on the right identifies, however, there were a number of complications concerning the delivery of BCT itself and its capacity to undergo a significant evaluation of this kind. These challenges were identified from a number of sources: through monthly meetings with the BCT Research and Evaluation Group (REG), conversations with staff and stakeholders, discussions within the evaluation-led workshops (see Chapter 3), and qualitative data collection. These challenges, in turn, lead to practical difficulties being raised for the evaluation; these are detailed, alongside the routes taken by the evaluation team to ensure gathering an evidence-base for NCM delivery continues to move forward.

It should be noted that it is understood that a number of very similar challenges are being reported by vanguard sites across the United Kingdom, and, it may be argued, that some are to be expected for ambitious large-scale change programmes.

Following the interim report on 18/04/2017, evaluators and commissioners started discussions concerning the next stage of the evaluation and the most beneficial areas to focus on. This led to the identification and recommendation of three specific areas which would inform both the tail-end of the first twelve-month project, and the continuation of the evaluation project across 2017-18. These were the development of Integrated Care Communities (ICCs) in Barrow Town, Bay and East; and the evaluation of a specific intervention within each of these: from the Respiratory pathway (Barrow Town), Paediatrics pathway (Bay) and Frailty pathway (East).

5 <https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf>

Area	Specific issue for NCM delivery	Specific issue for evaluation	Resolutions for evaluation
Strategic	<p>The scope and boundaries of BCT as an entity are often unclear.</p> <p>Differing understanding and little consensus between senior staff as to the nature and purpose of BCT.</p> <p>No clear timescale for when changes are expected to take effect.</p>	<p>Difficulty for participants in identifying what part of their work is 'vanguard', 'BCT' or something else.</p> <p>Challenges in identifying meaningful outcomes.</p> <p>Lack of a clear and consistent criteria for 'what success looks like' and benchmarks to evaluate outcomes and impact from.</p>	<p>This report identifies gaps in data and suggests methods for addressing them.</p>
Structural	<p>Pathways lack specific output metrics; over-dependency on high-level outcome data e.g. ED Attendance.</p> <p>Information Governance processes has been slow to be put in place.</p> <p>Pace of change is slow: several interventions and pathways still taking shape at the time of the evaluation.</p> <p>Successful interventions involve very small numbers.</p>	<p>Difficulty in tracking patient flow and identifying key enabling or disabling points within pathways and interventions.</p> <p>Difficulty in identifying inputs to an activity (e.g. resource) to match against outputs.</p> <p>Challenges in locating up-to-date documentation around pathways and interventions.⁶</p> <p>Lack of access to quantitative data for first eight months of project.</p> <p>Difficulty in working back from high-level outcome metrics to specific interventions – cause and effect difficult to demonstrate (see below, section 2.2).</p>	<p>This report establishes general contexts, mechanisms and outcomes of NCM. The next 12 months will concentrate on more focused pathways and areas.</p> <p>The evaluation examined generative causality as a way of capturing change and impact in the absence of clear or appropriate baselines and targets.</p>
Cultural	<p>Numerous historical and geographical contexts affect the delivery of BCT across Morecambe Bay.</p> <p>BCT is delivered alongside other changes at both local and national levels.</p>	<p>Some lack of engagement due to change fatigue.</p> <p>Concern that evaluation may not be seen as 'independent', and this may affect engagement.</p>	<p>The evaluation used emerging themes from qualitative data to inform the contextual analysis.</p> <p>Workshops provided open spaces for input and discussion of the programme in an independent space.</p>

6 'Documentation' here refers to intervention/pathway diagrams or narratives, lists of staff engaged, PDSAs,

2 Evaluation Methodology

2.1 Assessing Change, Outcomes and Impact

HASCE were commissioned by Bay Health and Care Partners to undertake a qualitative evaluation of the NCM, and, where appropriate, have triangulated our findings with other sources in order to assess change, outcomes and impact of the vanguard site. The findings in this report are based on five sources in particular:

- Perceived change reported by participants in qualitative research;
- Patterns of change suggested by quantitative data prepared by UHMB Business Intelligence for NCMT quarterly reports;
- Responses to an online survey of three ICCs;
- An economic analysis of cost-saving in relation to hospital attendance;
- Stated outputs and outcomes on the 2016/17 BCT logic model (see Figure 1 below).⁷

Qualitative analysis plays a key role in understanding and informing the development of the NCMs. The 'new' aspects which these care models bring pose a number of challenges to existing forms of data collection and measures. The scope of BCT, across an area as diverse as Morecambe Bay, brings a vast range of variables: some of which may directly affect the causal processes at work in the programme's delivery, some indirectly, and some not at all. As such, there is a clear need for attending to what Miles and Huberman call 'local causality – the actual events and process that led to specific outcomes'.⁸

This evaluation is based on a realist approach.⁹ This approach assumes that physical and social systems are ordered, yet infinitely complex. As such, no amount of observation or measurement will allow a complete understanding of their organisation. Instead, the realist approach analyses programmes and intervention in terms of their contexts, mechanisms and outcomes. This produces testable hypotheses on who a programme works for, in what context, and why; replacing overly-reductive outcome studies with an ongoing cycle of evaluation.

7 For the next stage of the evaluation, the evaluators will use the updated 2017/18 logic model. As this was finalised late in the timeframe of the first stage of the evaluation (and therefore would not have been in circulation when a large part of the data collection took place), it is not considered in this report.
8 Miles, M.B. and Huberman, A.M. Qualitative Data Analysis: A Sourcebook of New Methods. Thousand Oaks: Sage (1984), p.132
9 See Pawson & Tilley, Realistic Evaluation. London: SAGE (1997).

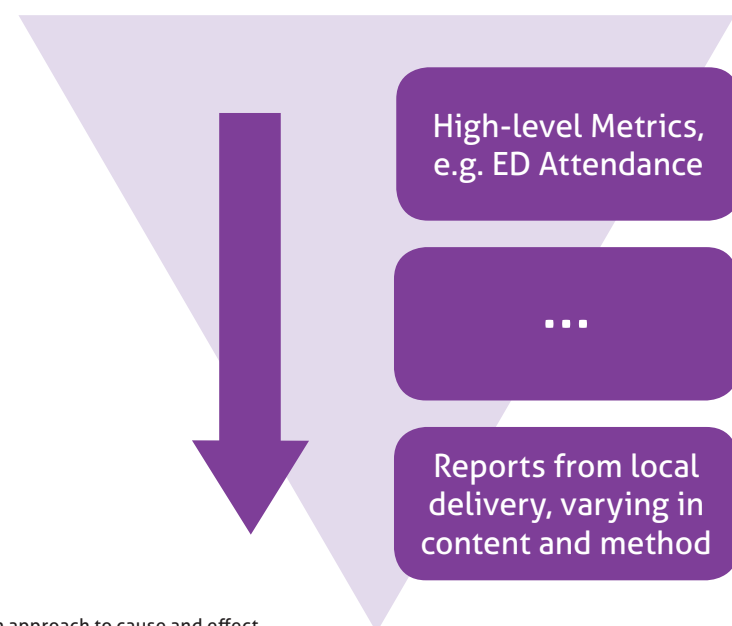


Area	Specific issue for NCM delivery	Specific issue for evaluation	Resolutions for evaluation
Evidence	<p>The apparent lack of (or provision of) overarching evaluation strategy, or evaluation criteria for assessing success of pathways.</p> <p>Lack of review and critique of internal evaluations (e.g. PDSAs). Inconsistent data reporting for comparison across areas/interventions.</p> <p>Evaluation is often left to the end of delivery of interventions, rather than embedded from the start.</p> <p>There appears to be a tendency to rely on, and trust, anecdotal evidence of change rather than rigorous qualitative analysis.</p>	<p>Given the complexities, inconsistency in data availability and challenging landscape, expectations from commissioners can be ambitious.</p> <p>Information regarding existing or contemporaneous evaluation work, either external or internal to BCT, was not shared with the evaluators.</p> <p>Risk of duplication of evaluation activities.</p> <p>Difficulty in detailed comparison across areas.</p> <p>Differing expectations from participants and stakeholders about the vanguard evaluation itself.</p> <p>Lack of engagement, or reluctance to engage, by participants in some areas of delivery.</p>	<p>The report suggests evaluation criteria for areas moving forward.</p> <p>As part of the 2017/18 evaluation, the evaluators will deliver training to BCT staff around embedding evaluation into programme delivery.</p>

► Table 1 Summary of Challenges for Delivery and Evaluation of BCT

The following report provides:

- A detailed account of the qualitative themes and configurations in response to the NCMT questions, triangulated with quantitative outcomes where appropriate.
- A general map of hypotheses regarding cause and effect across the NCM as a whole, which will inform the next stage of evaluation of specific interventions and ICCs.
- An economic analysis of cost reduction, which establishes the foundation for the next stage of evaluation around three specific ICCs.
- A summary of the 'active ingredients' of the NCM that have emerged to date in the course of the evaluation.
- The report can be read alongside the quarterly reports of quantitative metrics provided to the NCMT by UHMBT Business Intelligence.



► Figure 2 Top-down approach to cause and effect

The benefit of such an approach is that it allows population-wide changes to be identified straightforwardly, by mapping general trends, savings and improvements across the health economy. It has the added benefit of providing metrics that can be shared across pathways (for example, reducing hospital bed-days is a key part of all BCT activities).

This model also tends to privilege a 'successionist' model of causation;¹¹ in which causation itself is unobservable but is identified by observing two or more sets of (successive) data, and inferring a correlation between them. For example, the frequency of ED attendance pre-vanguard funding can be compared to the frequency post-funding. If the frequencies are significantly different, then a correlation emerges between vanguard funded initiatives and ED attendance, which can then be tested further. The benefit of this approach is its relative straightforwardness in identifying change and impact; hence, its usefulness for strategic overviews of programme effectiveness.

There are, however, limitations in this model. In terms of BCT, problems arise when attempting to ascribe changes in the high-level data to ground-level activity. Specifically, the causal relationship between ground-level activity of specific interventions and broader changes to populations cannot be reliably established, for several reasons:

- While high-level metrics can identify the success of well-defined pathways, they do not show the decision-making processes by individuals or groups which lead particular mechanisms to result in particular outcomes. As a result, there is no reason to accept that local interventions had an effect on the metrics any more than other interventions, or external influences.¹²

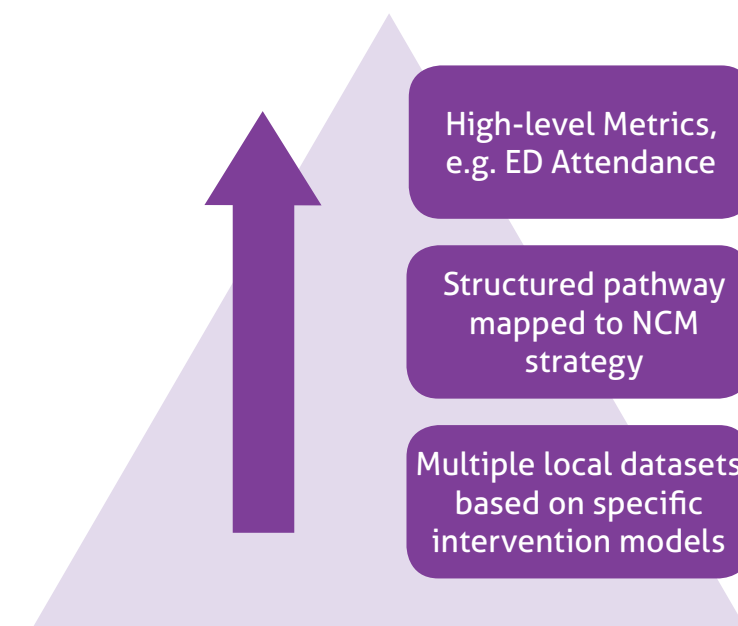
¹¹ Pawson and Tilley, *Realistic Evaluation* pp.32-3; Maxwell, J. A *Realist Approach for Qualitative Research*. London: SAGE (2012), pp.36-7

¹² For example, one influence on ED attendance external to the work of BCT could be social media announcements posted throughout 2016 and 2017 by UHMBT, advising the public against attending A&E. The effectiveness of these announcements as an influence on BCT's high-level metrics can, however, be challenged; see Appendix Seven.

- Successful pilot interventions within BCT (such as the Frequent Attenders pilot in Bay ICC) have typically worked with low numbers of patients and/or citizens, when compared to the population of the Morecambe Bay footprint as a whole, or even individual ICC populations.
- The larger metrics are often too abstract to track the kinds of changes the success of the NCM depends upon. For example, even though high-level outcomes are, in practice, improving, this may not carry with it the longer-term cultural change envisioned by a New Care Model.
- When assessing cause and effect in a complex programme such as BCT, identifying the most appropriate data to compare for successive causality can become speculative and contestable.
- Measuring 'inputs' and 'outputs' may risk missing the different elements that have to work together – often in iterative and mobile ways – within complex health interventions.
- For all of the points above, there is a gap in the data at the 'middle range' (represented in Figure 2 by a box with an ellipsis), where key data to bridge small-scale data and large-scale outcomes is not present.

With these limitations in mind, it is useful to note that during the evaluation, a number of interview participants voiced concerns and criticism over what they consider to be a top-down approach to change. These concerns can be summarised as a perception that focussing on high-level outcomes is likely to miss the more nuanced changes taking place within the NCM.

In contrast, to the approach above, Figure 3 is a 'ground-up' approach to mapping cause and effect, which this evaluation aimed to deliver.



► Figure 3 Ground-up approach to cause and effect

Here, the expected causes and effects are mapped out prior to delivery and data is tracked up from local contexts to demonstrate what effect they should have on the higher-level metrics. Thus, as well as concentrating on service integration or redesign, there is a clear flow of data which links delivery activities to the outcomes used by the BCT delivery group.

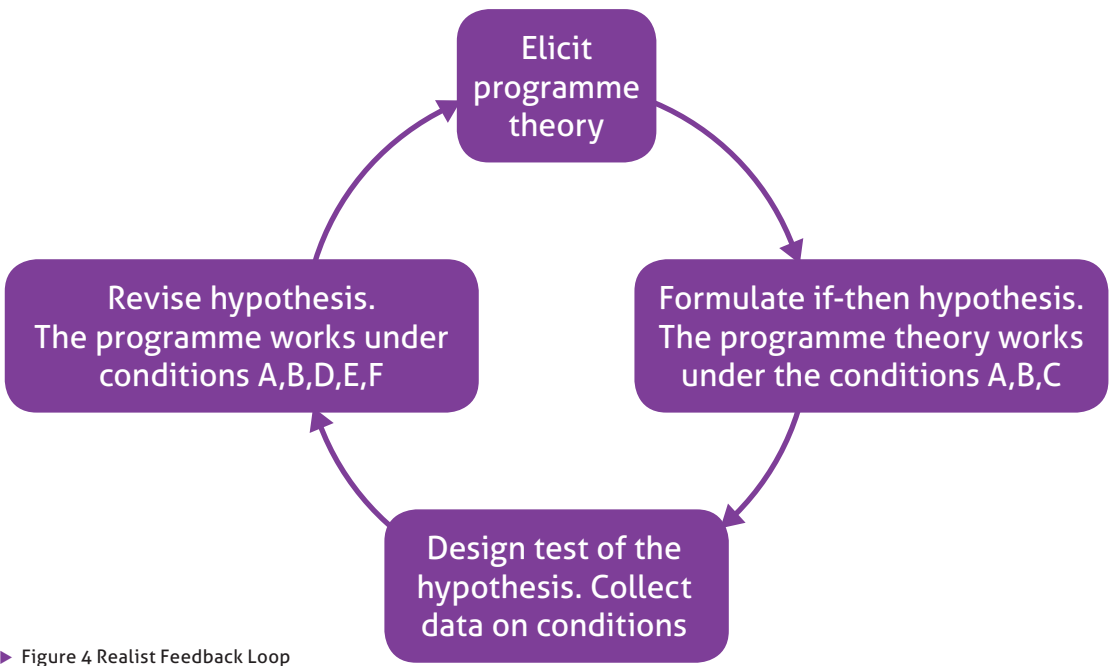
Because the ground-level changes focus on the choices and decisions that staff and citizens make within specific pathways (for example, a GP’s decision on whether to refer to a hospital consultant), this suggests a model of causation which is more ‘generative’ which can be summarised, thus:

*Actors and society have potential mechanisms of causation by their very nature. Change occurs when interventions, combined with the right contextual factors, release the generative mechanisms.*¹³

The generative causality model, then, sees causation as something real and identifiable and this is important to help understand our approach to the evaluation. Our selected methodology of realist evaluation is focussed on what mechanisms, in which contexts, allow change to happen and produce clear outcomes. When we map the complexity of a programme onto this context-mechanism-outcome (C-M-O) template, it facilitates the understanding/identification of how causation occurs (and this causation, as in the model above, should be real and identifiable).

This realist method, described above, was chosen for this evaluation for two primary reasons:

- It allows the complexities of interventions to be examined and evaluated, as part of an ongoing cycle of hypotheses-testing. It is possible for a C-M-O template to align qualitative themes with quantitative outcomes. In this way, it works by ‘scaffolding’ evidence of cause and effect from the ground up to the higher-level reporting metrics, and in doing so complement and support them (rather than replace them).
- It provides a way of improving qualitative data collection and analysis. One problem the evaluators faced was attempting to discern NCM achievements from aspiration, largely due to the slow pace of implementing change to frontline delivery. However, through the use of ongoing feedback loops (see Figure 4) qualitative data collection can be refined and structured as the NCM continues to develop.



► Figure 4 Realist Feedback Loop

¹³ Marchal, B., van Belle, S., van Olmen, J., Hoérée, T. and Kegels, G. Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. Evaluation 18: 2, pp. 192-212 (2012). P.202

2.3 Sampling Strategy

The sampling strategy forms a key part of developing a clear cross-sectional view of the delivery of the NCM. Given the size of the programme, it was clear that the evaluation must begin with a purposive sampling strategy – that is, gathered with a purpose in mind, as opposed to a random sample of participants. In this case, the sample comprised a range of individuals specifically selected for their various roles, knowledge and experience of the programme in order to capture a full range of perspectives.

Scoping meetings between the evaluation team, commissioners and work-stream project leads, facilitated the identification of ‘sample routes’ through particular projects. The evaluators then approached named project and clinical leads and from there followed a chain-referral (or ‘snowballing’) approach. This allowed researchers to move from the strategic level of delivery to the interface between staff and patients.

A purposive sampling strategy inevitably entails that not all views will be captured within the process data (due to time and resource constraint). However, this approach is not designed to audit BCT as a whole, but rather identify emergent themes around the contexts, mechanisms and outcomes of projects which could be used to identify causal factors for success, and carry into future implementation.

As well as enabling data to be collected from the ‘ground up’ and the ‘top down’ of the programme, the evaluation design aimed to collect data on both the successes of the programme, and understand why aspects of the programme may have taken longer to deliver, or not been delivered. By tracking the delivery of activities from the strategic and planning level to the frontline delivery and patient or citizen responses, the evaluation aimed to capture ‘cross-sections’ of structural, cultural, strategic and technological changes to the delivery of care. Based on project documentation provided by the commissioner, and initial discussions with workstream leads, the initial areas of sampling were selected:

- Projects already in delivery involving clinical staff, project staff and patients: Respiratory; Self-Care; Advice & Guidance; Women & Children’s Pathways Launch; Ophthalmology.
- Projects in development involving clinical and project staff. In particular, we were interested here in projects that had taken longer to implement, and what the perceived reasons for this might be: Children’s Alternatives to Admissions (A2A); Muscular-skeletal (MSK).
- Development of Integrated Care Communities (ICCs) involving community/clinical staff (e.g. case managers and care coordinators), project staff and citizens.

During the first six months of the evaluation it became clear that a number of projects were not at the stage of development expected based on programme documentation from the evaluation commissioning stage. As can often be the case with this approach to sampling, some routes did not develop a full referral chain, due to either lack of engagement, or changes to delivery plan: participants were often reluctant to engage around projects that had not delivered a successful outcome, while some staff were not available to discuss certain projects. Conversely, other routes developed more widely than had been anticipated: for example, the interest and involvement of non-NHS organisations in the NCM.

The data collection was initially guided by four elements based on the BCT programme design: Outcomes and Experience of Care; Quality and Safety; Cultural Change and Sustainability. These form the template for data collection activities (see Appendix One). All interview schedules covered these themes in their questions, although, dependent upon the participant’s role within BCT as well as how developed the activity was, some took a more central focus than others (this is discussed in Chapters 6-8 below).

This initial sample was based on staff and stakeholders. The original evaluation design was to track projects from planning to delivery, and impact on patients and citizens and so the latter months of data collection were focussed on these groups and their perceptions or experience of the programme delivery. Because many aspects of the programme had not reached the stage anticipated when the evaluation was commissioned, participants from service delivery and management voiced a number of concerns that patients would not yet be feeling the effects of interventions. This led to a redesign of the sampling of patients and citizens in the second half of the evaluation.

Patient and citizen representation was taken from focus groups. The sample for these was identified following discussions with the evaluation commissioners regarding the 2017/18 evaluation. As a result of these discussions, the evaluators initially contacted patient participation groups and voluntary organisations which were either a) involved in one of the three pathways which form the focus of the second stage of evaluation: respiratory, paediatrics and frailty; or b) active within one of the three ICCs selected as a focus: Barrow Town, Bay and East.

Following on from these focus groups, a more detailed analysis of patient and citizen experiences that have been directly involved in BCT interventions or activities will form part of the 2017/18 evaluation work.

Focus groups have been ongoing between September and November 2017. This report includes analyses of data collected from 34 participants. The emphasis of the focus groups was on understanding what the patient experience has been of the BCT initiatives under evaluation, and what factors have been most affective in this, covering:

- Attitudes and feelings towards the healthcare system, in particular relation to respiratory, frailty or paediatric pathways and the changes that these interventions have brought;
- How their access to care has or has not changed during the course of the programme;
- Changes in expectations of care from their local health providers.

The focus group schedule can be found in Appendix Three.

For the 2017/18 evaluation, specific patients who have been through the selected interventions will be contacted for interviews and/or focus groups. As this data has yet to be collected, the focus groups with patients and citizens aimed to provide a general narrative in relation to the contexts, mechanisms and outcomes of BCT in these particular areas. This will form the foundation of the analysis of impacts on patients and citizens during 2017/18.

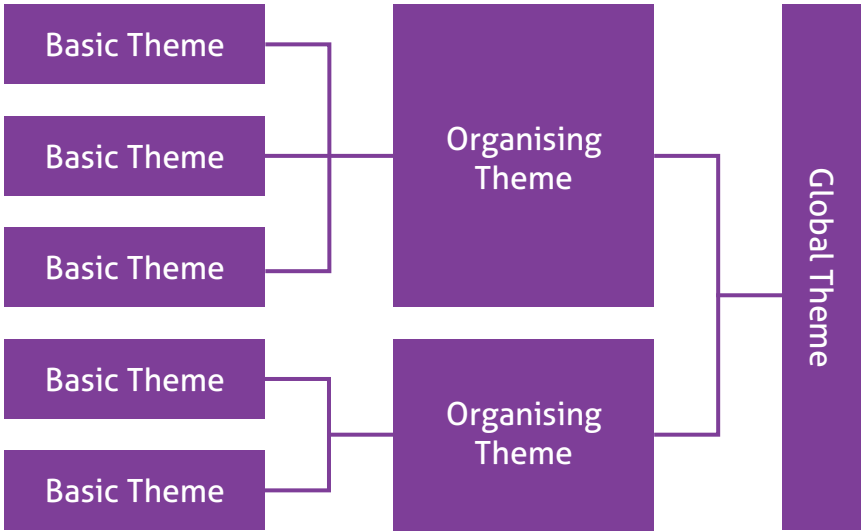
Participant Background	Data Collection Method	Number of Participants (up to 30/10/2017)
Clinical	Semi-structured interviews	24
Project	Semi-structured interviews	24
Local Authority, Third Sector and other non-NHS	Semi-structured interviews	6
Patient/Citizen	Focus groups	34

► Table 2 Evaluation sample size to date

2.4 Data Analysis

Data was collected from interviews with staff and stakeholders, and focus groups held with patient groups. The interview and focus group data was analysed initially for themes, which were then categorised as 'basic', 'organising' or 'global'. As Attride-Stirling notes, this approach does not initially 'aim or pretend to discover the beginning of arguments or the end of rationalizations; it simply provides a technique for breaking up text, and finding within it explicit rationalizations and their implicit signification.'¹⁴

Basic themes grouped together under shared assumptions can be identified by an organising theme, and likewise global themes can be broken down into constituent organising themes, as illustrated in Figure 5:

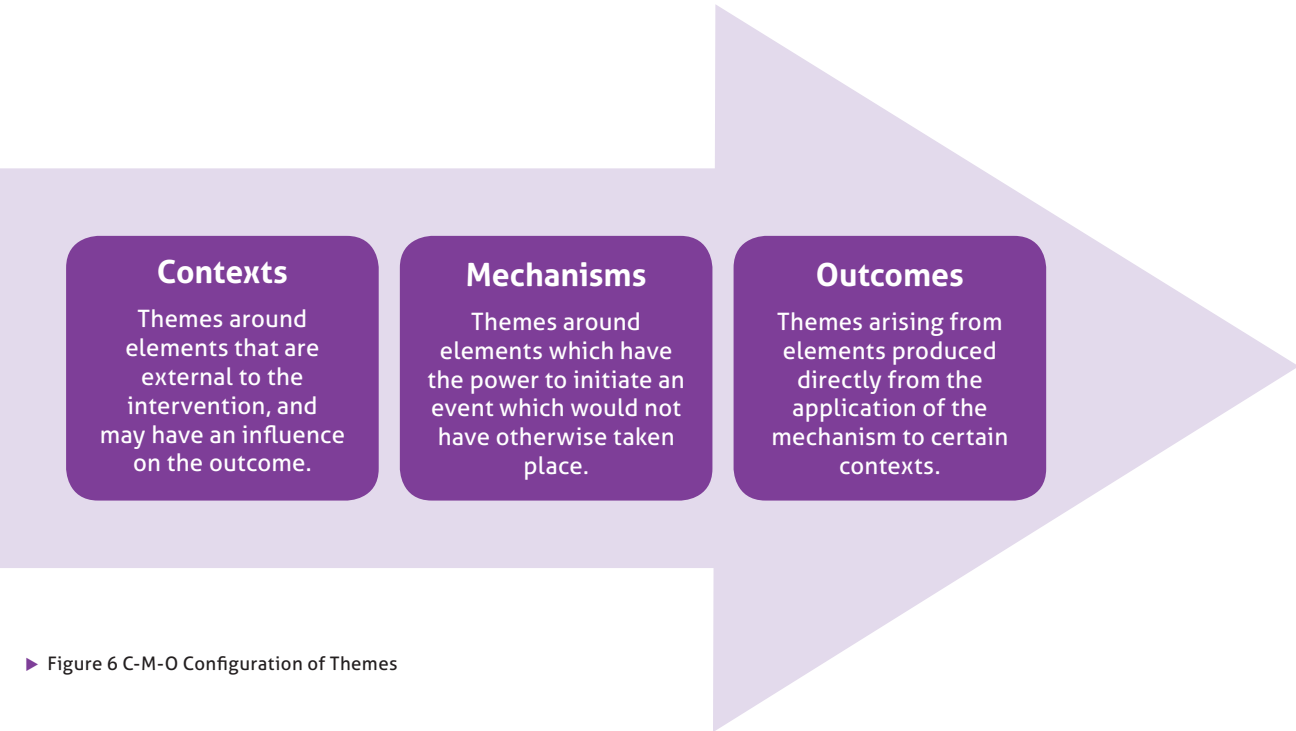


► Figure 5 Levels of Qualitative Analysis

Initial analysis of the interview and focus group transcripts produced over 500 pages of basic themes, which were then grouped into organising themes, and then more general, global themes. Alongside this category based analysis, the researchers also applied a connective analysis, which involved identifying themes within participant narratives as 'enabling' or 'disabling'. This aimed to capture how change was developing within the often complex and unfolding NCM contexts. Some themes were also labelled 'ambivalent', typically where themes emerged around possible future events or changes which could not reliably be seen as enabling or disabling yet.

14 <http://utsc.utoronto.ca/~kmacd/IDSC10/Readings/text%20analysis/themes.pdf>

In order to propose cause and effect to the changes taking place within the NCM, the themes were analysed and arranged into context themes, mechanism themes and outcome themes. This facilitated in-depth analysis of each emerging theme, as well as the hypothesising the connections which would suggest causal links between themes.



In determining what should be seen as a context or a mechanism, we followed Marchal et al. in considering context to be elements that are 'external to the intervention, present or occurring even if the intervention does not lead to an outcome, and which may have an influence on the outcome.'¹⁵

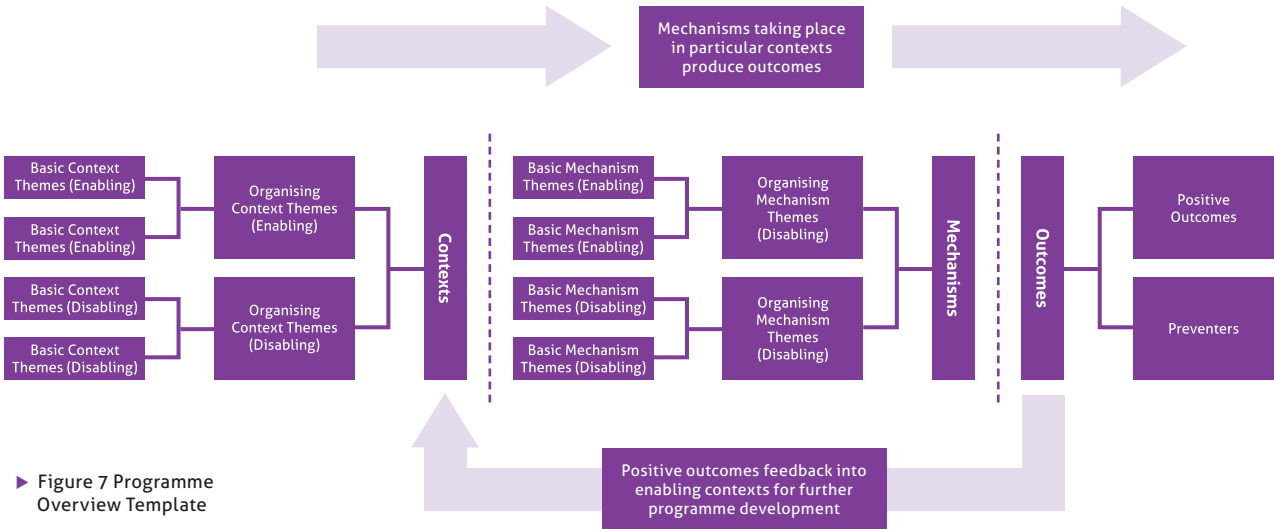
Mechanisms, meanwhile, are particular things which have the power to initiate an event which would not have otherwise taken place. 'Integration of services,' for example, can be understood as a strategic mechanism for BCT, because it initiates several of the outcomes of the NCM.¹⁶

Outcomes, meanwhile, should describe events which are produced directly from the application of the mechanism to certain contexts. Outcomes, in this sense, are not simply proof that a programme 'works', but are used to test whether the hypothesised connection between contexts and mechanisms is reliable.

¹⁵ Marchal et al., Is realist evaluation keeping its promise? P.207
¹⁶ Crucially, mechanisms can take a wide range of forms. Thus, integration of services is a strategic mechanism which can be broken down into a number of constituent parts, which may include psychological mechanisms (e.g. trust between individuals working within different services), social mechanisms (e.g. the enabling of discussion which ensures successful integration), technological mechanisms (e.g. data sharing), and so on.

A benefit of the application of this C-M-O template is that it can use different forms of data, and it has been used in this way here. The bulk of our evaluation data collection focused on semi-structured interviews and focus groups; responses from these are most likely to focus on mechanism themes. Context and Outcome themes, meanwhile, can be aligned with quantitative data to support the cause and effect suggested in the qualitative findings.

In principle, this method can produce hypotheses around what mechanisms carried out in what contexts are causing particular outcomes to occur (see Figure 7).



However, it should be understood that this ordering is always hypothetical rather than a direct representation and, so, while it is very useful in this type of evaluation, alongside it the evaluation team must make informed decisions on how the data is themed and ordered.

In this project, the validity of the data analysis was established through dialogue with the Research and Evaluation Group (REG), three workshops run for stakeholders (see Chapter 3), and an Outcomes Survey (see below, section 2.5), as well as a number of informal conversations with stakeholders in and around the evaluation. The data analysis will continue to be tested and modified in the 2017/18 evaluation work, by focusing on a smaller number of specific interventions.

2.5 Outcomes Survey

In the initial evaluation plan, a large-scale outcomes survey was planned which would provide a means to testing the hypotheses around the changes effected by the New Care Model.

As documented in Table 1 above (section 1.3), the evaluation has experienced a number of challenges in data collection, following changes to programme delivery, variations in timescales across different interventions and workstreams, and no clear consensus between stakeholders around what success would look like.

As is to be expected in an iterative evaluation project, there have been changes in the initial evaluation data collection strategy, and this also raised questions as to the appropriateness and usefulness of an outcomes survey at this point of the Care Model’s delivery. These questions were informed by the following concerns:

- The reach of the survey was likely to be limited; discussions with the BCT communications team suggested a figure of c.250 people may be likely to engage with a general survey.
- The data collected suggested very strong themes, which, the evaluators felt, were unlikely to be modified by a larger survey.
- The qualitative data suggested that the most significant changes occurring were routed in specific relationships at an individual level. It would follow, therefore, that localised analysis of causation would be more beneficial than a more overarching, general view.
- Because BCT operates within a range of other contexts, a large scale survey would risk missing key details, rather depth, quality and robustness of data would be better achieved via different means to facilitate participant reporting on specific BCT outcomes (rather than more general perceptions of care) – for example, an explanation of what a workstream has achieved to date.

In response to these concerns, evaluators distributed a smaller-scale survey (see Appendix Two), within the three ICC sites for the 17/18 evaluation, in place of a large outcomes survey. The smaller-scale survey was aimed at staff in primary care, social care and the voluntary sector, based on those involved in, or affected by, interventions currently in place within each ICC. The distribution followed a cascading strategy, beginning with ICC leads and core teams and was available to complete online for five weeks in September and October 2017.

The surveys focused on two key outcomes, based on the qualitative findings: the extent to which there is a shared understanding of roles and responsibilities within the ICC, and the level of engagement/disengagement that participants report for the appropriate BCT workstreams. The surveys used a combination of attitudinal Likert scales and open-box responses to provide quantitative and qualitative measures for these themes.

The response rate was very low, with only 13 surveys being completed. While this cannot be considered as a representative sample, analysis of the survey responses provides some additional and valuable insight into experiences of the ICCs. These findings have been summarised in Appendix Six and are to form the basis of further qualitative work in the 2017/18 evaluation during which a second survey will be distributed, with the aim of increasing participation, particularly across GP practices and community groups involved in the ICCs.

2.6 Ethical Considerations

The evaluation adhered to an ethical code of research conduct throughout the project. Where appropriate, data collection and analysis was approved by the University of Cumbria’s Research Ethics Committee.

When undertaking focus groups with patients and citizens, participants were not asked about specific conditions or treatments, in a way that might involve divulging personal information. They were, instead, be asked about their experience of the specific changes brought about by the New Care Model.

It was of vital importance to the evaluators that anonymity of participants needed to be preserved. In the findings presented in this report, quotations from participants have been double-coded in order to prevent any contributions being traced back to individuals. Interviewees are thus labelled INT001, INT002, etc., and focus group participants are labelled PARTICIPANT 1, PARTICIPANT 2, etc. Where appropriate, text from quotes has been redacted where information, or a combination of information, may identify a participant.

2.7 Limitations, Issues and Adjustments

The realist approach to evaluation is entirely appropriate to this type of project however, one limitation is that the model has a dependence on clear programme ‘theories’ being apparent from the outset of delivery, particularly within health systems.¹⁷ Similarly, the ‘ground-up’ model described in section 2.2 and 2.4 is an ideal schema, whereby the clarity of cause and effect depends very much on the clarity of the programme structure. In practice, it can be difficult – and not always useful – to decisively separate themes out as ‘contexts’ or ‘mechanisms’; this is made easier when clear outcomes are identifiable, but given the iterative nature of much of the BCT programme, this was not always possible.

- To address this, the initial context-mechanism-outcome configuration was adjusted to a wider set of categories; these allowed the ongoing and iterative nature of change mechanisms to be accurately represented, as well as the complexity of the systems they were placed within. The conventional realist configuration was expanded to represent context, enabler, disabler, mechanism, preventer and outcome.

A key challenge in the work here was the apparent lack of consistent documentation on, for example, intervention/pathway maps, inputs and resource use, and localised outcome data.

Instead there appears to be some reliance on anecdote and ad hoc feedback. It is likely that this situation has arisen from a number of relevant contextual factors, but it should be noted that from the perspective of an independent evaluation, it does pose challenges for a system-wide ground-up, qualitative approach.

Identifying clear outcomes proved to be a difficult task for the evaluators with a range of complications; some outcomes were yet to appear, others are not currently reported in a consistent form, while some are too broad to attribute to specific changes within the programme itself. For example, certain Integrated Care Communities (ICCs) are described in the data as ‘more developed’ than others, but it is not clear if these align to specific metrics or KPIs, and whether these might be comparable across all ICCs.

- In response to this, the evaluators have drawn out some of the key themes around success and outcomes in this report which may help to support the development of more robust, and locally-sensitive, metrics.
- The evaluators used quantitative metrics to triangulate outcome findings, and use these to identify further areas for analysis. In order to adjust for this, data collection took on more of a scoping function, in order to understand the realistic state of the programme.

¹⁷ See Julnes, G., Mark, M., and Henry, G. Promoting Realism in Evaluation: Realistic Evaluation and the Broader Context. Evaluation 4:1 483–504 (1998).

In addition, a further challenge to the evaluation rollout is the wide variation in levels of engagement with the project, as well as access to relevant and up-to-date documentation. In some cases, the 'projects in development' sampling route did not generate enough participants to warrant pursuing. In other cases, there was little enthusiasm amongst participants for discussing projects that had not been deemed successful.

- Adjustments were made to the original sampling strategy: the 'projects in development' sample route was merged with an additional route engaging a broader range of non-NHS stakeholders in service delivery.

As well as these 'ground-level' challenges, a more strategic issue is that there appears to be no overarching evaluation strategy for the programme. This is problematic, particularly given the large scale and scope of the project, the latter being difficult to pinpoint exactly. Most critically, the lack of strategy entails that there was the possibility of multiple research and evaluation activities (for example, PDSAs) were taking place around Morecambe Bay with risk of duplication or lack of shared learning. A strategy in place may also have helped manage expectations as to what this evaluation project would be able to deliver with the time and resources available.

Given the challenges noted above, this twelve-month report presents findings, but also a number of gaps in data which the evaluators feel are significant in being able to identify what outcomes are coming from the vanguard site, and how these are being caused.

The limitations and adjustments have guided the development of a second stage of evaluation in 2017/18, where smaller, more clearly-defined activities will provide a focus for answering the NCMT questions.



2.8 Discussion and Summary

The ambition of the NCM requires a more nuanced approach to cause and effect than frequency and correlation, as this is unlikely to capture the specific kinds of change, and the incremental progress this may take.

- Measuring start points and outcomes does not capture the different mechanisms that have to work together in order to link the two in complex health interventions.
- In its current form, the quantitative data reported to the NCMT is not connected to clear models of inputs, outputs and outcomes.
- For this reason, the commissioners have been clear from the project's inception that the evaluation should involve a whole programme approach, rather than a work-stream-by-work-stream study. This approach entirely befits the ethos of the BCT programme.
- At the same time, problems can arise when there is ambiguity over key boundaries for the evaluation: in particular, the size and shape of particular interventions, where BCT 'begins' and 'ends' in terms of inclusion of activities, and the specific contribution of vanguard resources to existing interventions in relation to other funding sources.

The evaluators initially used the realist approach of configuring context, mechanism and outcome in order to explain the changes taking place. However, several factors complicated this approach.

- Due to the size and scope of BCT, there are a number of different timescales for delivery for projects. In some instances, it appears there is a lack of a clear timescale for expected outcomes. This has led to adjustments in the original evaluation approach.
- The lack of clarity around specific mechanisms, and the complexity of the systems they were placed within, led the evaluators to modify and expand their categories in order to represent the change process, to context, enabler, disabler, mechanism, preventer and outcome.

The absence of an overarching evaluation strategy embedded within the delivery of the NCM is considered to be problematic.

- This means that there has been the risk of duplication of evaluation activities, and differing expectations from participants and stakeholders about the vanguard evaluation itself.
- The lack of clear and consistent criteria for 'what success looks like' makes evaluation fundamentally difficult.

At the present time, localised qualitative data plays a key part in identifying the contexts, changes and outcomes of the NCM. Much of the evidence of change in relation to the specified outputs of the BCT logic model currently resides in qualitative work.

Following the production of the interim report (April, 2017), the evaluation and commissioners discussed how sampling routes could be focused and refined in order to address the main problems the initial evaluation faced. This has shaped the commissioning of the second stage of the evaluation, whereby the focus will be on three ICCs and three specific pathways.

- The evaluators are therefore presenting here general findings around the NCM with more detailed analysis of specific interventions to follow in the next 12 months.

3 Evaluation Workshops

The evaluation project was two-tiered: alongside its frontline evaluation activities, the evaluators also delivered three workshops over the 12-month period. These were designed so emerging findings could be fed back to stakeholders, and which a) allowed the evaluators to modify and refine our data collection in dialogue with those involved in delivering the care model and b) sought to establish a foundation for ongoing evaluation amongst stakeholders once the NCM evaluation had finished. HASCE presented these workshops with support from the Bay Learning and Improvement Collaborative (BLIC).

3.1 Workshop One: Evaluating Better Care Together

The first workshop took place on 21st February 2017, and brought together stakeholders from health, social care and the third sector to discuss the ways the progress and impact of BCT is evidenced and valued. The event utilised an Open Space format, where participants were encouraged to identify ‘conversations’ that mattered to them around BCT. Each conversation was given a separate discussion space, and participants were free to join and exit conversations as they wished.

The initial aim of the workshop was to discuss and develop ideas on how evaluation could be embedded successfully at the core of BCT, both now and in the future. There was a sense, from the conversation topics put forward, that the question of evaluation had to proceed from some more fundamental discussions around, for example, improving communications, as well as examinations of broader issues such as territorialism around roles and funding.

The conversations had the following headings:

- How do we establish trust between stakeholders?
- Do we have a sense of where we are going?
- How do we redistribute resource without affecting service?
- Making children’s voices heard in an Adult/BCT world
- Empowering people to diagnose cancer
- How do we make the important measured, and not the measured important?
- What does integrated IT look like?
- How can people learn/share/develop the population health initiative?
- What are the design principles that underpin all we do?
- Is a clinically led NHS achievable?
- How do we optimise the assets of individuals, communities and partners, including elected politicians at all levels of government?
- Cultural change amongst BCT stakeholders

The discussions were captured on ‘harvesting sheets’, which were made available on the evaluation website designed for this project.¹⁸

While the purpose of the workshop was not necessarily to produce consensus, it was notable that a number of key themes started to appear across different conversations, these comprised:

- Having the right people ‘around the table’ for decision-making (at every level), and ways in which this might be achieved; for example, how we know who the ‘right’ people are, and how accessible the table might be for them.
- Whether the balance of priorities for BCT was appropriate, both in terms of the focus of care, and in terms of who leads this focus.
- The significance of relationships and personalities to programme success.
- The importance of case studies, stories from the ‘ground up’ and qualitative evidence of what works, in order to help continue to shape the delivery of BCT.

It was interesting to note that these themes reflected a number of emerging findings from the process evaluation at that point, specifically around the importance of ground-level qualitative data, and questions around ‘what success looks like’ at the end of the programme.

3.2 Workshop Two: Whose Knowledge? What Evidence? Which Data?

The second workshop took place on 23rd May 2017 with the purpose of the workshop of discussing the creation, collection and use of data from across health providers, support services and the community to support the NCM.

The workshop was attended by some 33 delegates¹⁹ from across BCT including clinical and non-clinical staff and representatives from local authority, public health, third sector and NHSE. As previously, the workshop used an ‘Open Space’ format which provided opportunities for participants to suggest topics and questions for discussion around the data that is being collected across the whole of BCT, and how it might be used to evidence success.

The day began with an update from the evaluation team on the current evaluation. There followed the Open Space format, where participants were encouraged to discuss and develop ideas on how evaluation can be embedded successfully at the core of Better Care Together, both now and in the future. These conversation topics were suggested by participants, and individuals were free to attend, contribute to and move in between those conversations. The agreed conversations were:

- People using the Third Sector
- What would success mean to the patient?
- What is an appropriate metaphor to convey the BCT vision?
- How do we remove fear of change?
- Ensuring equity, governance & challenge
- How informed are the public about NCM?
- Addressing equality and diversity
- How do we measure success in BCT?
- How do we challenge the Postcode Lottery?
- How do we mainstream ideas?
- Patient empowerment & citizenship
- How do we shift/transfer resources in line with the BCT strategy?
- Improving staff engagement

From the evaluator’s perspective, there were a number of interesting themes emerging from discussions; two of the most prominent themes concerning evaluation specifically were:

- How organisations could assess the success of collaboration, across sectors and geographies (e.g. primary and secondary care, voluntary sector).
- The importance of effective communication.

The BCT evaluation website provided some further information for participants on the main methods of applying evaluation to these areas.²⁰ This information is summarised as part of Appendix Five.

¹⁹ Over 60 were registered for the event; unfortunately, a major traffic incident on the day of the workshop led to many delegates being unable to attend.
²⁰ <https://v3.pebblepad.co.uk/spa/#/public/94jgbwjbdRgs6xg3qyR9d4p37W?historyId=CCkBWc0A5q&pageId=94jgbwjbdRgs9hg%t946xq7MGmr>

¹⁸ <https://v3.pebblepad.co.uk/spa/#/public/94jgbwjbdRgs6xg3qyR9d4p37W?historyId=CCkBWc0A5q&pageId=94jgbwjbdRgs94Gz38xdzfp7gc>

4 Findings

The key point arising from these themes was that a definition of successful engagement or successful communication was fundamental to evaluating success. However, different contexts may involve a different definition of success. As such, attempting to use a universal category such as 'effectiveness of public engagement' must be accompanied by a clear articulation of the time and space that engagement takes place within, so that success can be compared across them.

For example, it was noted that attention must be paid to how, where and when questions are asked, and how this might implicitly 'shape' the responses, as well as the conditions determining the 'effectiveness' of an engagement. Likewise, there was a discussion of how engagement in evaluation needed to show results – feeding back on a process needed to have a visible effect (whatever that might be) in order for it to be worthwhile; otherwise, participants may be less willing to engage at all. It was considered these will all affect the success of an evaluation.

3.3 Workshop Three: Evaluating Cultural Change

In the initial evaluation proposal, a third workshop was planned which would follow the establishment of multiple new pathways, to provide a context for discussing issues around cultural practices, barriers and solutions, which would then contribute to thinking around the longer-term sustainability of the NCM. While delivery had not reached this stage, the workshop on cultural change was nevertheless felt to be timely. The workshop took place on 19th September 2017, with the purpose of discussing the evaluation of changes in the culture of healthcare provision within the BCT programme.

The workshop was open to staff in primary and acute care, community teams, third sector organisations and patient representative groups and was attended by 60 delegates from across BCT including clinical and non-clinical staff and representatives from local authority, public health, third sector and NHSE. This workshop was run as a World Café model, to provide opportunities for participants to discuss pre-selected topics and questions around cultural change. The wide range of views from across the health economy, helped to articulate the key successes, and main obstacles, to the kinds of cultural change which Better Care Together aims for.

After an opening presentation from Dr Alex Gaw, Chair of the BCT Research and Evaluation Steering Group, and Dr Tom Grimwood, Lead of this evaluation, on cultural change and evaluation, participants were asked to join one of seven tables. Each table was tasked with a specific question around cultural change in BCT. Groups had 30 minutes to discuss the question and populate a harvesting sheet, before moving on to a different table. There were four rotations in the course of the day. To conclude, a plenary discussion was held, where the most prominent questions from the day's table discussions were put to a panel of senior figures.

The harvesting sheets were structured to elicit more focused responses than those of the first two workshops as evaluators were keen to understand how participants viewed the successes of BCT to date, and what they envisaged as the main obstacles to success. The harvesting sheets from the workshop are presented in Appendix Three. In many senses, these provide a clear snapshot of the state of BCT at the current time. When read in conjunction with the evaluation analysis (Chapters 5-9), they serve to support a number of the findings.

4.1 How the Findings are Presented

Because of the complexity of the NCM, it can be challenging to isolate variables affecting individual aspects of change. At the same time, evaluation requires a degree of abstraction in order to 'make sense' of the work of the programme. In order to present this in as coherent a way as possible, the evaluators have presented their findings in three ways:

- First, as overarching mechanisms in the configuration table detailed in section 4.2 below. This configuration forms the basis of the evaluators' responses to the research questions set out by the NCMT. Each question is mapped to one of five headings: contexts, mechanisms, resources, outcomes and active ingredients.
- Within each of these chapters (with the exception of Chapter 9), the main headings from the configuration table are then broken down into thematic overviews, to illustrate their component enabling and disabling themes.
- These themes are then detailed in a narrative response, which forms the substantial part of each chapter. The narrative responses attempt to show the generative causality within the context of service delivery. Findings are discussed and summarised at the end of each chapter.

It is important to note that the evaluation was not tasked with (and was not encouraged to deliver) a pathway-by-pathway audit. The subject of this report is an analysis of why certain changes have happened where others have not, what components of the NCM have been most effective in contributing to positive change, and how similar the enablers and disablers have been across workstreams, pathways and interventions.



4.2 Configuration of Hypotheses

Contexts	Disabling Mechanisms	Enabling Mechanisms	Overarching Mechanisms	Preventers	Outcomes
Geography and Demographics		Community mobilisation	Integrated Care Communities	Staff attrition	Improved self-care in citizens
		Care coordination			
		Localised solutions through flexible working			Patients receive appropriate care in an appropriate place
		Improved use of technology			
Skill Supply	Time needed for development	Care planning	Integrated working		Improved quality of care
		Dialogue and communication			
		Non-financial resources inc. upskilling			
Availability of Resource	Clarity, perceptions and balance of distribution of funding		Insufficient metrics		Non-sustainable change
Previous Interventions		Enthusiasm for change			Reduction in costs
Organisational Cultures	BCT as a disabler for long-term change		Cultural change	Disengagement at key points	Visible progress (at high-level and local levels)
		Incremental change			'Joined-up' care for patients
	Pace of change				
		Broader understandings of wellbeing			Overcoming organisational barriers
	Lack of clarity around BCT – vision, leadership and decision-making				

► Table 3 Configuration of Hypotheses

The configuration table presents a schematic view of the development of the NCM. The entries in the table refer to broad themes, which are discussed in detail in Chapters 5-9. The table is to be read from left to right, beginning with the contexts for NCM delivery, across to the outcomes currently being evidenced, or identified as prospective outcomes for the work being done.

This allows for outline hypotheses to be drawn across the contexts, mechanisms and outcomes of the programme, taking into account the interrelation of different themes.

Each overarching mechanism for achieving these outcomes is preceded by smaller mechanisms which occur before the broader mechanism take place. These are either enabling (ingredients for success) or disablers (obstacles to be overcome). In some cases, disabling and enabling mechanisms will be in play simultaneously (where they appear next to each other on the table); in others, it is theorised that an obstacle will prevent the enabler emerging. In between the broad mechanisms and outcomes are preventers: these occur after the mechanisms have been instigated, but prevent full outcomes being reached.

The outcomes column is supplemented below with possible measures to evidence their success. As Chapter 8 details, not all of these measures are currently active, and their development forms part of the report's recommendations.

While a range of tools for measuring these forms of outcomes exist, there is no single measure which will demonstrate the effectiveness of the changes BCT is implementing; and the coordination of a range of measures will be the best way of assessing outcomes overall.

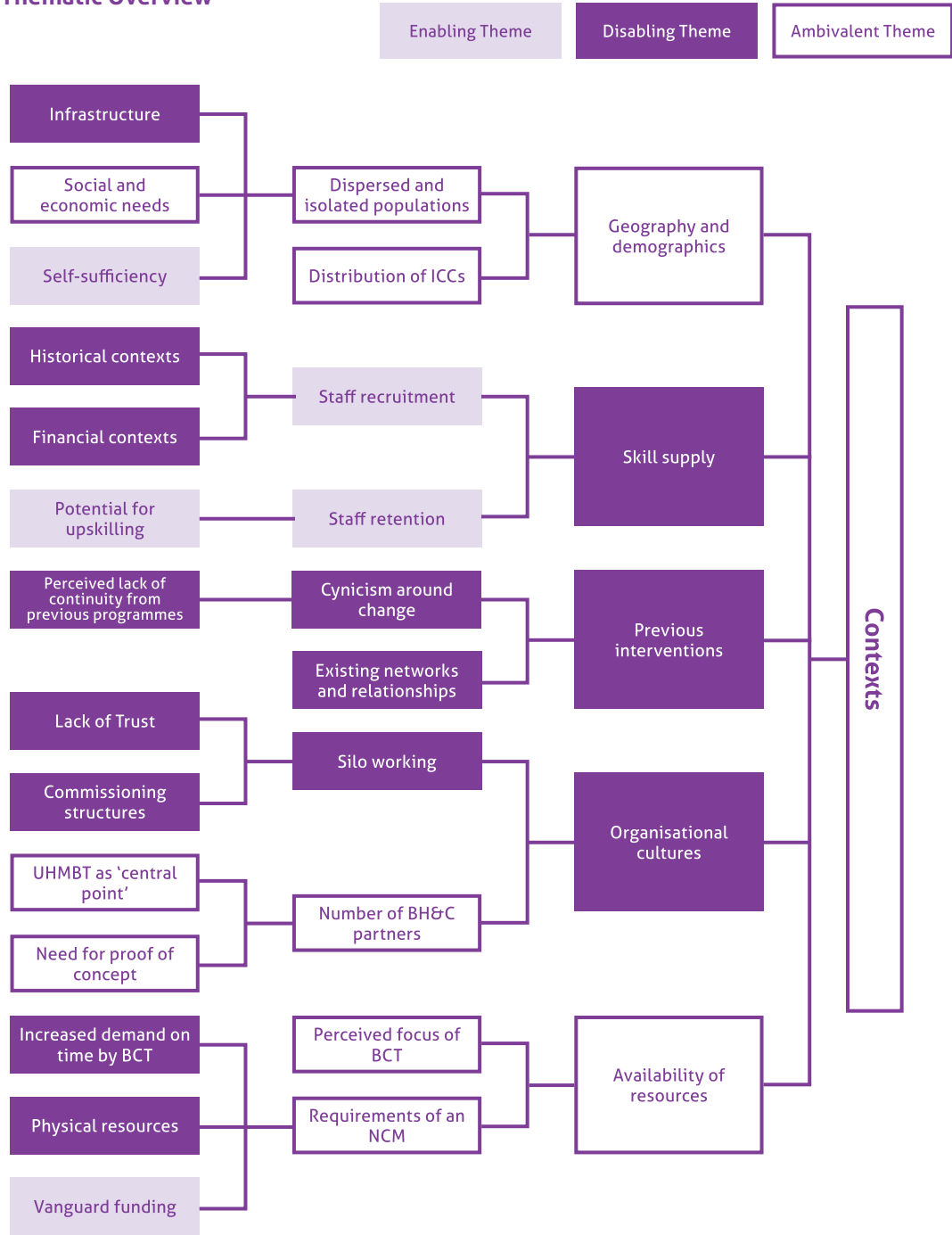
Outcome	Potential Measures
Improved self-care in citizens	Sustained reduction in non-elective admissions in areas of self-care projects Qualitative feedback from ICCs
Patients receive appropriate care in an appropriate place	Improved patient satisfaction ratings Qualitative feedback from ICCs
Improved quality of care	Existing pathway-specific care quality measures Reduction in re-admission rates for specific pathways Improved patient satisfaction ratings for specific pathways
Non-sustainable change	Lack of improvement (qualitative and/or quantitative) and progress in pathway implementation against specified and contextualised timescales
Reduction in costs	Reduction in cost per capita Measures of non-financial resource (e.g. time); improved use of shared resources
Visible progress (at high-level and local levels)	Improved high-level metrics (BCT quarterly reports) Measures for incremental and qualitative change and local levels (see Appendix Six)
'Joined-up' care for patients	Patients tracked through specific pathways Qualitative feedback from staff and patients
Overcoming organisational barriers	Evidence of shared decision-making Evidence of good communication and engagement (see Appendix Six)

► Table 4 Outcomes and Potential Measures

5 Contexts

Evaluation Question:
What is the context in each vanguard into which new care models have been implemented?

5.1 Thematic Overview



► Figure 8 Contexts - Thematic Diagram

NCMs are complex programmes that are being implemented within complex systems, and each system has a context that is shaped by unique local historical, demographic and organisational factors. These contexts are aspects which exist regardless of the programme itself, but nevertheless affect its implementation and success, so identifying its key features is necessary to understand the conditions for delivery. For the purposes of this evaluation, contexts were identified using the VICTORE model,²¹ which has been developed within realist evaluations to map contextual factors. This has been used to inform the analysis of the data collected in Stage One of the evaluation of the NCM. A narrative of these findings is presented below.

5.2 Geography and Demographics

The geographical features of Morecambe Bay comprise key enabling and disabling contextual factors, as would be found in any geography. Morecambe Bay covers a geographical area of 1,800km², which is double that of the average Trust nationally, but its 365,000 population is smaller than that of some urban areas.²² The distance between services, and from major city hospitals, is recognised as a key challenge to BCT.²³

The challenges associated with low population density with diverse, and sometimes isolated, communities were commonly cited by participants in their descriptions of the NCM. BCT has used GP practice populations across south Cumbria and north Lancashire to divide its footprint into 12 Integrated Care Communities. These communities cover geographical and demographically distinct populations, such as the industrial Barrow-in-Furness in South Cumbria, the picturesque villages of the South Lakes and the city of Lancaster. Participants described the implications of these different health and social care needs of these communities on the provision of care, for example:

My ICC has two geographically quite different areas. We've got the South Lakes and Ambleside, Windermere, versus the Grange Peninsula. So that's a potential issue for my ICC, that they are two quite different areas geographically and demographically, with different challenges. So the Grange Peninsula has a lot of nursing homes and an ageing, frail population, and then the Lakes tend to have more affluent and holiday maker, temporary residents. (INT050)

21 This model categorises contextual data in terms of Volitions (the choices available to stakeholders), Implementation (the chains of resources, responsibilities and governance involved), Context (demographic concerns, on both micro and macro levels), Time (previous histories of interventions within the locality), Outcomes (the monitoring systems available), Rivalries (the pre-existing policy landscape in which the intervention is embedded) and Emergence (the potential effects and unintended consequences of the intervention).

22 University Hospitals of Morecambe Bay. Summary of our Five Year Strategic Plan 2015-2020. (2015) <https://www.uhmb.nhs.uk/files/bct-publications/NHS-M-Strategy-Plan-2015.pdf>

23 The Better Care Together Strategy for the Future for health and care services in Morecambe Bay. (2015) <https://www.uhmb.nhs.uk/files/bct-publications/Better-Care-Together-Plan.pdf>

These needs and other demographic characteristics have been well documented elsewhere and therefore a detailed analysis is not repeated here. A summary is however presented in Table 5 below to highlight the key features of Morecambe Bay by ICCs.²⁴

ICC	Population	Key Features
Millom	11,767	<ul style="list-style-type: none">A coastal area in South Cumbria, on the edge of the Lake DistrictHigher than average older population (24% compared to English average of 17.2%)5.4% are unemployed, higher than the English average of 4.4%*Life expectancy for males (78.3) and females (81.3) is lower than the English average (79.5 and 83.1 respectively)
Alfred Barrow	27,372	<ul style="list-style-type: none">Located in South Cumbria, includes coastal areas5.5% are unemployed, higher than the English average*Higher than average older population (20.5% compared to English average of 16.9%)Life expectancy lower for males (76.9) and females (81.2) than nationally
Barrow (profile based on 'Barrow Other')	33,774	<ul style="list-style-type: none">Located in South Cumbria, includes coastal areasHigher than average older population (25.3% compared to English average of 16.9%)5.0% are unemployed, higher than the English average *Life expectancy lower for males (76.9) and females (81.2) than nationally
Ulverston, Dalton and Askam	25,400	<ul style="list-style-type: none">South Cumbria, on edge of the Lake District24.1% are aged 65 years and over, higher than the national average3.5% are unemployed, lower than the national average*Life expectancy higher for males (80.7) and females (84.7) than nationally
Grange and Lakes	31,854	<ul style="list-style-type: none">Located in South Cumbria, includes Lake District villages of Grasmere, Ambleside and WindermereHigher than average older population (31.3% compared to English average of 16.9%)Low unemployment rate (0.8%)*Higher life expectancy for males (80.7) and females (84.7) than the English average

24 Sources: all data for Cumbria ICCs: ICC Profiles, 2017, Cumbria Intelligence Observatory; data for Lancashire ICC s: Clinical Commissioning Group Profiles, 2015, Lancashire County Council, unless indicated with *. All data indicated with an * is from PHE's National General Practice Profiles.

ICC	Population	Key Features
Kendal	36,826	<ul style="list-style-type: none">South of the Lake District in CumbriaHigher than average older population (23.6% compared to English average of 16.9%)Low unemployment rate (1.6%)*Life expectancy for males (80.7) and females (84.7) is higher than the English average
East	32,313	<ul style="list-style-type: none">Located in South Cumbria, incorporates a small part of the Yorkshire Dales National ParkHigher older population (30.2%) than national averageLow unemployment rate (1.6%)*Life expectancy higher for males (80.7) and females (84.7) than national average
Carnforth	14,920	<ul style="list-style-type: none">A rural and coastal area on the boundary with South Lakes26.4% of the population is aged 65 years and over*Low unemployment rate (0.0%)*Life expectancy higher for males (80.4) and females (84.4) than national average
Bay	70,097	<ul style="list-style-type: none">Includes the coastal areas of Morecambe and Heysham in Lancashire21.2% of the population is aged 65 years and over3.9% unemployment rate*Life expectancy is lower for males (76.1) and females (80.9) than the national average
Queen Square	13,642*	<ul style="list-style-type: none">Located in the city of Lancaster18.4% of the population is aged 65 years and over*Unemployment rate lower than national average (2.9%)*Life expectancy is lower for males (78.5) and females (82.8) than the national average*
Lancaster	54,630	<ul style="list-style-type: none">Includes the city of Lancaster and surrounding rural areasOnly 13.4% of the population is aged 65 years and over*Low unemployment rate (1.5%)*Life expectancy is lower for males (78.2) and females (82.1) than the national average
Garstang	18,192	<ul style="list-style-type: none">Rural area that covers parts of Garstang, Catterall and Calder27.0% of the population is aged 65 years and over*Low unemployment rate (1.6%)*Life expectancy of 79.6 for males and 83.2 for females is comparable to the national average

► Table 5 Summary of Geography and Demographics of Morecambe Bay by ICC

Although some ICCs have a higher proportion of older people than others, an ageing population with complex and multiple needs was recognised as an increasing source of pressure on health and social care in all areas. For participants, there was a direct link between social isolation and care needs; in the absence of regular social contact, there was an increased dependence on services. Furthermore, it was believed that needs may not be recognised until an acute care admission was required.

For others, the rurality of some communities, and the perception that transport links are poor, created a more general sense of isolation.

I think a lot of the problems with the vulnerable people in Kendal, who do feel a bit isolated, it's to do with transport really, a lot of it. Especially for the people in the outlying villages, because the public transport is poor. So if something could be thought about to help people get to places, that would go a long way into helping people's health improve, because they'd feel able to go to things and engage, rather than being isolated where they live. (INT007)

The geographic isolation was also described as affecting adults of a working age. Some of the more isolated communities were perceived to have complex social and economic needs:

Unemployment is a massive issue; drug use is a massive issue; poverty is an issue. You know, all the issues of deprivation really. (INT010)

Despite the challenges presented by the geography, remoteness also facilitated the adoption of more creative working practices. Millom's location, which was '30 miles from each large town' or 'in the back end of beyond' (INT051), meant that different working practices had to be adopted.

Its isolation has always meant that we've had to do things differently to everywhere else. So, we've always been, to some extent, more self-sufficient, because we've had to be. Because you know, we are an hour away from most of the big hospitals at Whitehaven and Barrow. (INT052)

5.3 Skill Supply

The retention and recruitment of staff was commonly described as a factor affecting both the set up and delivery of the NCM. High staff turnover rates were reported across a wide range of roles, including commissioning, management and clinical. Furthermore, the geographical location, and the relative isolation of some communities, created recruitment difficulties; one remote area was described as being seen 'as a bit of a backwater' professionally (INT057) and as a result, there had been six Consultant Geriatric vacancies at one time. Another participant described how there was an increasing move to sessional and flexible working within general practice, but the remoteness of areas such as Millom restricted the ability to achieve this:

We've still got massive problems trying to recruit and that again is a geographical problem, is that the way the General Practice has become structured, with a lot more part-time Doctors working, a lot more sessional Doctors working, because they want much more flexibility. Which is fine if you're living in the middle of Manchester, you've got much more options, but if you're a doctor as well, or a nurse and working, whereas if you're in deepest, darkest Cumbria, if you're in Millom, you're stuck. (INT052)

In addition to rurality and distance from other services, the reputation of Morecambe Bay was also cited as a challenge to recruitment. As one participant described, the Trust was perceived to have been 'dragged through the mill. That doesn't help us when we try and recruit.' (INT024).

Recruitment challenges were perceived across general practice, nursing, and specialisms such as paediatrics and psychiatry, and allied health professionals. Outside the NHS, home carers were reported to be in short supply with an accompanying reliance on a temporary workforce.

Participants described their frustration at the capacity of care teams and their ability to implement the NCM. Staff shortages were seen as a challenge in the shift from hospital to the community, and integrated care more generally.

I don't think in the current climate of financial and human resources, that it is possible to transfer care to the community, unless something drastic is done...nothing is going to work. They might as well stop the programme, stop wasting more money and get back to actually doing the job that they should be doing. This cannot work unless they find more social care, and they find more people to provide primary care or community care. (INT025)

...there's not enough home care. People have been stuck in the hospital because they can't get home...It's very rural. You can't get people to work. (INT048)

I think there's a lot of cynicism amongst GPs who are thinking, "yeah, yeah, you want to bring everything out into the community but we don't even have enough GPs to do the work that we're doing at the moment, or community staff, or District Nurses, or anybody else in the community to do the work." It all feels a bit implausible. (INT029)

Despite staff shortages, one NCM initiative was able to develop after physiotherapists across the Morecambe Bay footprint were identified as having under-utilised skills. These physiotherapists were over-qualified for their job (for example, they had a PhD or Masters level qualification) and were able to use their skills in a musculoskeletal project. The Commission for the Future of Primary Care suggests such upskilling is necessary to increase the capacity of primary care teams, and in turn enable them to respond to the demands of NCMs.²⁵

5.4 Previous Interventions

Because those involved in the design and implementation of a programme are active rather than passive participants, their actions are informed by their choices and preferences (their volitions). For the NCM to succeed, stakeholders are required to engage with the process of change, however, the interview data indicates that willingness to engage varied. Perceptions and experiences of previous interventions are an important factor here. The NHS has been subjected to change for decades and more locally, Morecambe Bay has its own portfolio of transformation programmes, some of which are running concurrently with the NCM. The vanguard status was awarded in March 2015, but the Better Care Together programme was set up in 2013. Other relevant transformation programmes which either border or cross into BCT's area include the Success Regime in West, North and East Cumbria and the Sustainability and Transformation Plans for North Cumbria and for Lancashire and South Cumbria. The Morecambe Bay Investigation of maternity services was also cited as an important catalyst for change by participants.

Participants reported that this on-going cycle of change had created cynicism or negativity amongst staff and other stakeholders:

There is always, depending on individual personalities, there are always people that are more frightened than open than others, to changes. And to be quite honest, the NHS has seen so many changes. It's a constantly changing beast, so sometimes the staff are quite cynical and quite a lot of the time, quite rightly so, about changes in the NHS because there are so many changes on regular occasions that people do sense that this is just another one, just another change and we don't really know what's in it for us. (INT062)

There's always going to be issues with staff...you have to try to communicate with staff to say that yes, change is happening, but often people can associate change negatively rather than positively. The automatic reaction is that something is changing and so something negative is going to happen to us. (INT053)

25 Primary Care Workforce Commission. The Future of Primary Care: Creating Teams for Tomorrow. (2015) Available at https://www.hee.nhs.uk/sites/default/files/documents/WES_The-future-of-primary-care.pdf

For others, who had been involved in similar interventions previously, the NCM was a source of frustration and they questioned why yet more of their time was required to set up the same process again. Muscular-Skeletal (MSK) care is one example of this; participants reported setting up a Steering Group in 2015 in response to what was perceived to be poor provision.

If you're talking about the time that people have inputted into the project, it's been very poor use of our time, because this is about the third time we've been around the houses doing the same thing and coming up with the same results. (INT029)

Participants also described how differing views of Steering Group members shaped the development of the project:

The initial phase of that Steering Group development involved an awful lot of discussion between what were quite disparate areas, in terms of the vision. It took longer than expected to develop an agreed vision. To be honest with you, we've still got some differing views on how these services should be developed. (INT039)

For others, their ability to engage with the NCM was constrained by the ongoing measurement of their performance against previous KPIs:

Our commissioning arrangements don't support it [change], because I'm still held to deliver on previous KPIs. So, if we can't double run, the only way we can do it is to move our deck chairs. But if I'm held to deliver on previous KPIs, I can't move my deck chairs in the way that I need to, to enable that change to happen. (INT043)

In contrast, other previous initiatives appeared to facilitate the NCM. In Millom, an alliance was formed in 2014 in response to the threatened closure of the local hospital. The Millom Alliance brought together the Millom Action Group (which represented the local community), a GP practice, Cumbria Partnership NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust and South Cumbria Clinical Commissioning Group (www.millomalliance.nhs.uk). In doing so, the relationships and connections required by the NCM were already in place:

Millom's quite different to a lot of the other ICCs in that the Millom Alliance has been in place prior to the ICC, really. So we've got the Community Health Action group and the community are really involved in the work that we're doing and really on board with that. (INT054)

Similarly, collaborative networks were reported to have been established for Women and Children's Services workstream (WACS) before the NCM was introduced:

The work had started before there was ever such a thing as BCT, that we had come together across a wide range of stakeholders, including third sector, including local authority, including acute and community and primary care – and worked up a model of the best way to deliver healthcare for [...] women and children. This work was already underway when BCT came along and absorbed it. (INT013)

Understanding the function and role of partner organisations is an important factor here; it is this understanding that appears to have created an enabling context for NCM. This theme is discussed further in Chapter 6 and 7.

5.5 Organisational Cultures

There was a strong feeling amongst participants that a departmentalised culture was prevalent across BCT partners and was a key disabler. For some, this related to the organisational structure of the NHS. The approach to commissioning was attributed with the creation of a fragmented service and even competition between primary and acute care providers:

...[the] NHS has been set up over the years, is to build teams in silos. So you have a community team, and even within a community you can have different parts, or different community teams that are commissioned separately, that have different responsibilities, separate targets, separate KPIs. So consequently, when the commissioning system is set up like that, when you commission services, you inevitably commission services which are going to be fragmented. (INT022)

The divide of different organisations who are meant to compete, and who are meant to purchase care from each other, isn't a recipe for trying to make people get on. (INT024)

More generally, it was felt that the number of partner organisations, and their operation across county boundaries, compounds the complexity of BCT's delivery. For example, each organisation has a procedure for data collection and therefore the data that can be collated to evidence the success of the programme varies:

There's lots of barriers to change. The culture is a barrier to change, I suppose the fact that we're having to wipe away years of splits between different parts of the NHS. We're working with 11 different partners, all of which are statutory organisations, all of which have their own agendas. We are having to remove all of those and come to agreements about how people will work together. (INT016)

So, there are 14 [sic] major players, statutory bodies in the area, in the patch, that all employ staff and have different responsibilities. And so, the only unifying point is UHMBT, as the acute Trust... (INT056)

We're sat here to try and reduce admissions and we know we're here to try and reduce excess bed days. How can we do that with BCT? What can BCT bring to the table to help the social aspect, that the NHS is not in control of? That's our frustration. (INT047)



Participants highlighted the CCG boundary changes as a further source of complexity. In 2017, a new Morecambe Bay CCG covering North Lancashire and areas of South Cumbria, and reconfigured North Cumbria CCG were established. It is apparent that there were mixed feelings on this change; although some welcomed the fact that the CCG footprint would now mirror that of partner organisations), others were concerned about the administrative implications of the move. For example:

...it makes sense in that three hospitals now are a lot more linked to one CCG. I suppose with that there are some concerns about, is that going to add value to BCT or is it going to detract away from it, because are people going to spend the next year sorting out the admin and process for the boundary change? (INT027)

More generally, the slow and complex interaction between BCT partners was a source of frustration. There was a perception that decision making was slow, with agreed actions from one group being referred to another for approval. For the voluntary sector in particular, the slow and complex interaction between BCT partners was a challenge to their way of working:

I'll be honest, I struggle to see how I fit in with the primary and acute Care, because we're not – I think the voluntary sector... to be able to sit at a strategic level and I think it's a very slow process for us to be involved in that very strategic level. (INT028)

The frustration experienced by the voluntary sector was echoed by other participants and attributed to the complexity of the BCT governance arrangements:

I think they get very frustrated with us, because they can see what needs changing but there's so many different partners that have to be engaged in Morecambe Bay, it makes it really, really difficult. (INT019)

A key and overarching theme here is the understanding of the different roles and functions performed by different organisations, and the teams within them. For example, in discussing the approach to re-enablement, one participant described how lack of awareness affected services:

So there might be a reacting or a re-enabling team, and lots of social care type teams, but then they seem to miss out the housing link quite often, or the Home Improvement Agency, which has the handyperson who can do small jobs and adaptations in people's houses to keep them independent, or to make sure they're not going back into an unsafe house. We struggle to get connected into the right people at the hospitals, to try and make that happen. (INT027)

An understanding of the respective roles of partners was required to enable the formation of relations built on trust, which was considered necessary for the development of the NCM:

I think there's been a lot of broken relationships - people not trusting each other. And without trust you can't progress. That trust is now building. It's not there in all avenues but it is building. (INT006)

The organisational culture is therefore a key contextual factor shaping the NCM's implementation. Individual working practices and cultures are also important here; NCM requires a new way of working, and an individual's willingness to engage with it is affected by a fear of the unknown (a risk averse culture) and the perceived threat to their role. To facilitate engagement, and overcome the fear created by the transformation process, participants described a need to first establish 'proof of concept':

There are always barriers to change. People's reluctance to work differently, people's reluctance to give up what is familiar, people's confidence in an existing system. And reluctance to take on what may be perceived to be untried or an untested system ... When we're asking people to work differently, ... sometimes [there are] many years of work that they have to unlearn ... "You want me to change 20 years of working practices and do it a different way. So, are you saying that for the last 20 years I've been doing this wrong?" And that's not always a message that people like to receive. Therefore, people can resist change and value, sometimes value efficiency of process more than outcome for patients. (INT013)

Because at the moment the ICC is a theoretical concept because they are not an entity as such. So in order to fully prove the concept, we need to make sure that all of the organisations involved feel quite safe and secure, that they're not going to be put at risk. (INT062)

...we had some excellent people called case managers and care navigators. We had those roles appointed within our ICC. Initially, like everything else new, people were sceptical and they didn't know how to use them. The people who were appointed didn't know how they could make a difference, or what their role was or how they could do it. ... No one likes coming in to a thing which is uncertain. So, if you decide to go down a route and make a change, then you just have to make it and sit back and let it work. It will take time, but unless you do that, you're not going to see the change. (INT025)

5.6 Availability of Resources

The NCM has been developed in a period of austerity, in which the NHS, social care and third sector partners have all faced significant financial pressures. For example, at the time of writing the Better Care Together Plan (2015), the University Hospitals of Morecambe Bay Trust had a £26.3 million deficit that was expected to increase in future years. Participants described how services had been realigned or even "retrenched" in response to such pressure, which in turn affected their ability to engage with the NCM. Changes to funding for Health Visitors and School Nurses were cited as one example of this:

The changes in the County Council funding of Public Health Services, so the Health Visitors and School Nurses, are really beginning to take effect and they've, they've just not been able to engage as much in the children's or maternity developments, because they've been going through a period of intense negotiation with the County Council about what they're being commissioned to do. (INT019)

The demand for social care, and the ability of social services to respond it, was also reported to affect the ability to deliver integrated care:

Obviously, the other big drawback at the moment is the stresses and strains that the Social Services are undergoing. That's a big barrier, because we can't put in the care that we need at an appropriate time, because of this restriction on accessing Social Services. (INT055)

Indeed, increasing service demands were reported to affect health and social care staff from both public and voluntary sector organisations, which in turn limited their ability to engage with the NCM. For example, senior staff in the voluntary sector were unable to attend every strategic meeting and in the NHS, healthcare professionals found the NCM's requirement to carry out duties and responsibilities that were additional to their 'day job' a challenge:

Although people really want to be able to be involved with improving services moving forward, there isn't always capacity, within the job plan to be able to do it. And you hear that across the whole health system. (INT001)

I'm not sure that it's been a barrier, but I think it's been a hindrance in that the people that are working on the vanguard have all got day jobs and other jobs that we do. The clinical leads and all of us, we've just got a set amount of time to dedicate to the vanguard work and sometimes there's a pull between the day job and other work you need to do. That's been a bit of a hindrance and I think we could have maybe moved faster if we could have had dedicated staff who were just doing this work. It isn't always possible to concentrate on the things we want to do at the time that we want to do it. (INT015)

I think releasing clinical staff and clinical duties is the biggy. Biggy, big, biggy. You know, because they are busier than they've ever been, and we're asking them to take time out to think about how the system could change. (INT058)

The lack of ‘vanguard funded time’ was a key issue here and as one participant described, engagement was often dependent on ‘goodwill’ (see Chapter 7 on resource use). Furthermore, where, roles were funded, the short term nature of the vanguard funding meant that they were fixed term posts.

The priority for the vanguard was also perceived to be on financial efficiencies, and achieving a reduction in outpatient appointments in particular, rather than the creation of improved patient pathways.

Because ... the whole focus of the programme was not ... necessarily about improving care, although there was obviously an element of that. How it was presented was “How you are going to reduce outpatient appointments.” Not about, “How you look at the holistic health of the population of Morecambe Bay and Barrow, etc. and let’s look at improving that.” (INT020)

The focus on cost-effectiveness was cited as another factor contributing to willingness to engage with the BCT programme:

I think the programme shot itself in the foot at the very start when they set it out, what needed to happen. And I think instead of it being our programme, that they looked at increasing the health of the population. I think it very quickly focussed down to saving money. And I think that really put a lot of people’s backs up. (INT020)

The availability, or lack of, more practical resources also emerged as a key contextual factor. For example, the physical space available in Morecambe Bay to deliver the NCM was cited as a disabler for the MSK project. There was a shortage of rooms in which the new service could be provided while GP practices in some areas were located in historic buildings that were considered non-compliant with accessibility requirements. However, another participant felt that there were buildings available for use within the voluntary sector, they were available free of charge but not thought to be fully utilised.

IT systems, and information governance procedures that determined access to IT, were identified as a complex disabler. Again, the number of BCT partners and their operation over county boundaries, was identified as a compounding factor here. One participant described the difficulties this created in accessing patient records:

BCT is obviously about a system-wide approach, but our individual organisations don’t allow us to deliver Better Care Together. So, the barriers if anything are the organisational constraints. Information governance is a killer. I’ve got into so much trouble, because you say it’s the right thing to do and therefore we should be sharing, but NHS England have come and said, here’s some money, with your vanguard status, deliver BCT. It’s such a great idea, we can learn from it. But what they haven’t done is set the permissions level to say, on this occasion, don’t worry about IT between organisations, that can be taken out, you can treat this as an open book. For me, the barriers have been the information governance, the technology systems that have got absolutely no way of speaking to each other. You pull off system data on the same patient population, you’ll definitely get two different answers. Without a shadow of a doubt, you will not be able to marry that up. (INT061)

5.7 Discussion and Summary

The NCM is being implemented in a complex context. Based on the data collected for this evaluation, the following points highlight the most prominent affective aspects of this, which have a direct bearing on the outcomes and impact of the work of the NCM:

- Geographical, demographic, historical and organisational features are interacting with the availability of resources to both enable and disable the programme.

- Morecambe Bay covers a large geographic area with a relatively sparse population (compared to other Trusts nationally). The distance between services and the geographical isolation of some communities is a challenge to the NCM.
- The 12 ICCs cover geographical and demographically distinct populations, which all have different health and social care needs. Although some have a higher proportion of older people (and Grange and Lakes the highest), an aging population with complex and multiple needs was an increasing source of pressure in all communities.
- Participants described how experiences of isolation affected the need for health and social care. Those without social and family networks were more dependent on services. Adults of a working age were also affected by isolation; the remoteness of some communities created complex social and economic needs, such as high unemployment rates. In this way, the demographics of the area form a key context of the delivery of the NCM.
- However, geographical isolation was also thought to provide opportunities for more community mobilisation, such as the creative working practices which had already emerged in more remote communities such as Millom.

The geographical location and distance between services was also identified as affecting staff retention and recruitment. High staff turnover rates and recruitment difficulties were reported for a variety of roles and participants expressed frustration about the lack of capacity in care teams to implement the NCM. This problem re-emerges later in the process as well (see Chapter 8).

Attitudes towards the NCM and engagement with it were affected by perceptions and experiences of previous interventions.

- Repeated cycles of change in the NHS, together with other transformation programmes, had created cynicism or negativity amongst staff and stakeholders. Other participants were frustrated about the need to invest more time in a project that was perceived to be the same as a previous intervention or that their ability to engage was hindered by the monitoring of performance against historical KPIs.
- In contrast, previous interventions also served to facilitate the delivery of the NCM in some areas. For example the collaborative networks established in Millom and for WACS were both cited as enabling factors.

Organisational cultures emerged as another important contextual factor.

- Where working practices were departmentalised, such cultures were a key disabler. Participants described how the restructuring of the NHS in recent decades had created a fragmented service that had a competitive approach to commissioning and different funding approaches.
- The number of BCT partners, and their operation across county boundaries, was perceived to have created complex and slow delivery processes. An understanding of the different roles and functions of each partner organisation was required to enable the formation of more effective working relations.
- Individual working practices and cultures was also identified as affecting the implementation of the NCM. For some, the transformation process was perceived as a threat to their role or a source of anxiety. Participants described how the NCM had to first establish proof of concept to facilitate engagement with it.

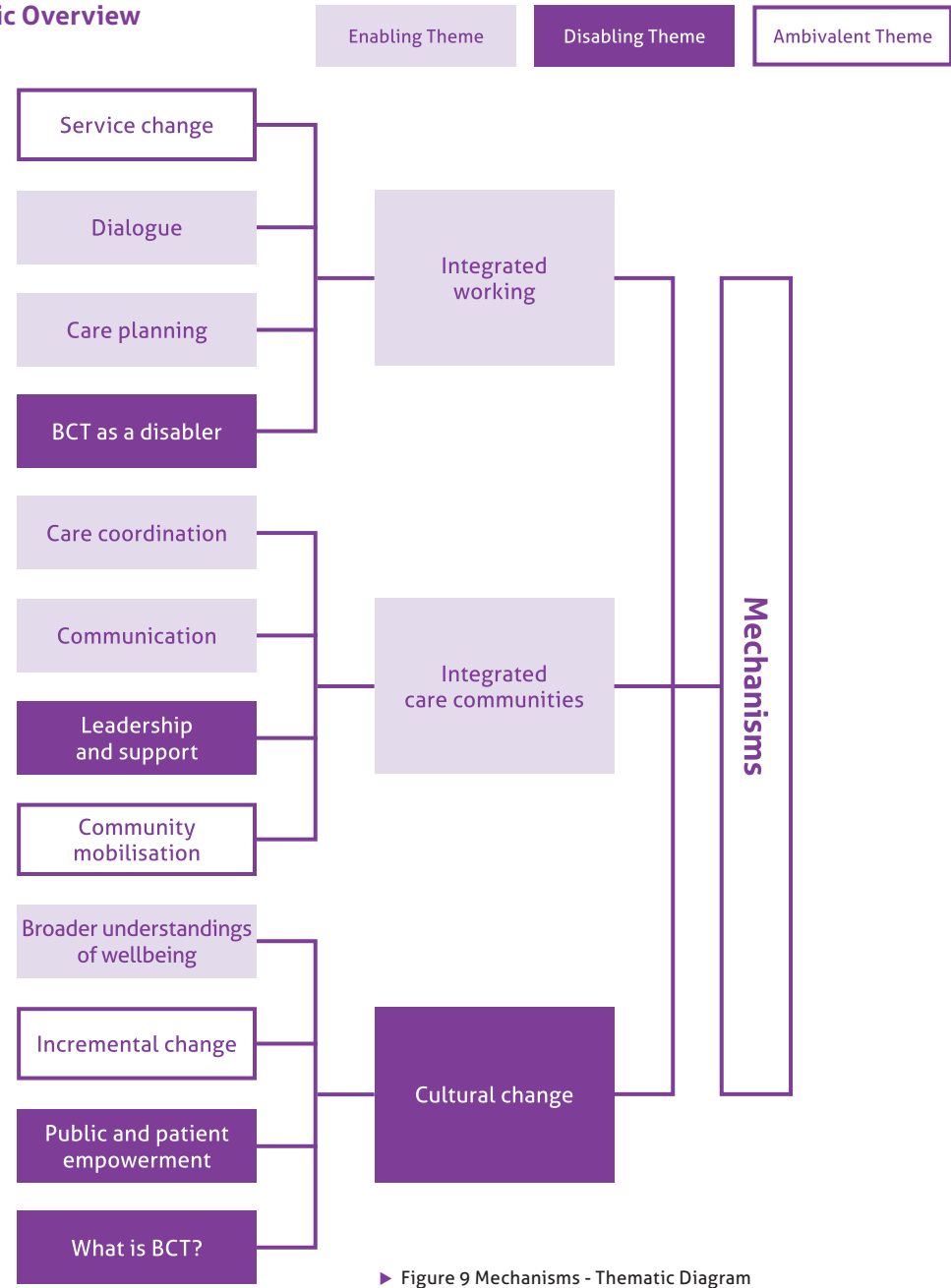
The availability of resources also shaped the NCM’s context.

- The financial pressures faced by partners, and increasing demands on their services, were described as a challenge – particularly given the lack of ‘vanguard funded time’ for some.
- Other resources, including a perceived lack of physical space to deliver new or different services in the community and the use of different IT systems across Morecambe Bay, were also described as increasing the complexity of the NCM implementation context.

6 Mechanisms

Evaluation Question:
What key changes have the vanguards made and who is being affected by them? How have these changes been implemented? Which components of the care model are really making a difference?

6.1 Thematic Overview



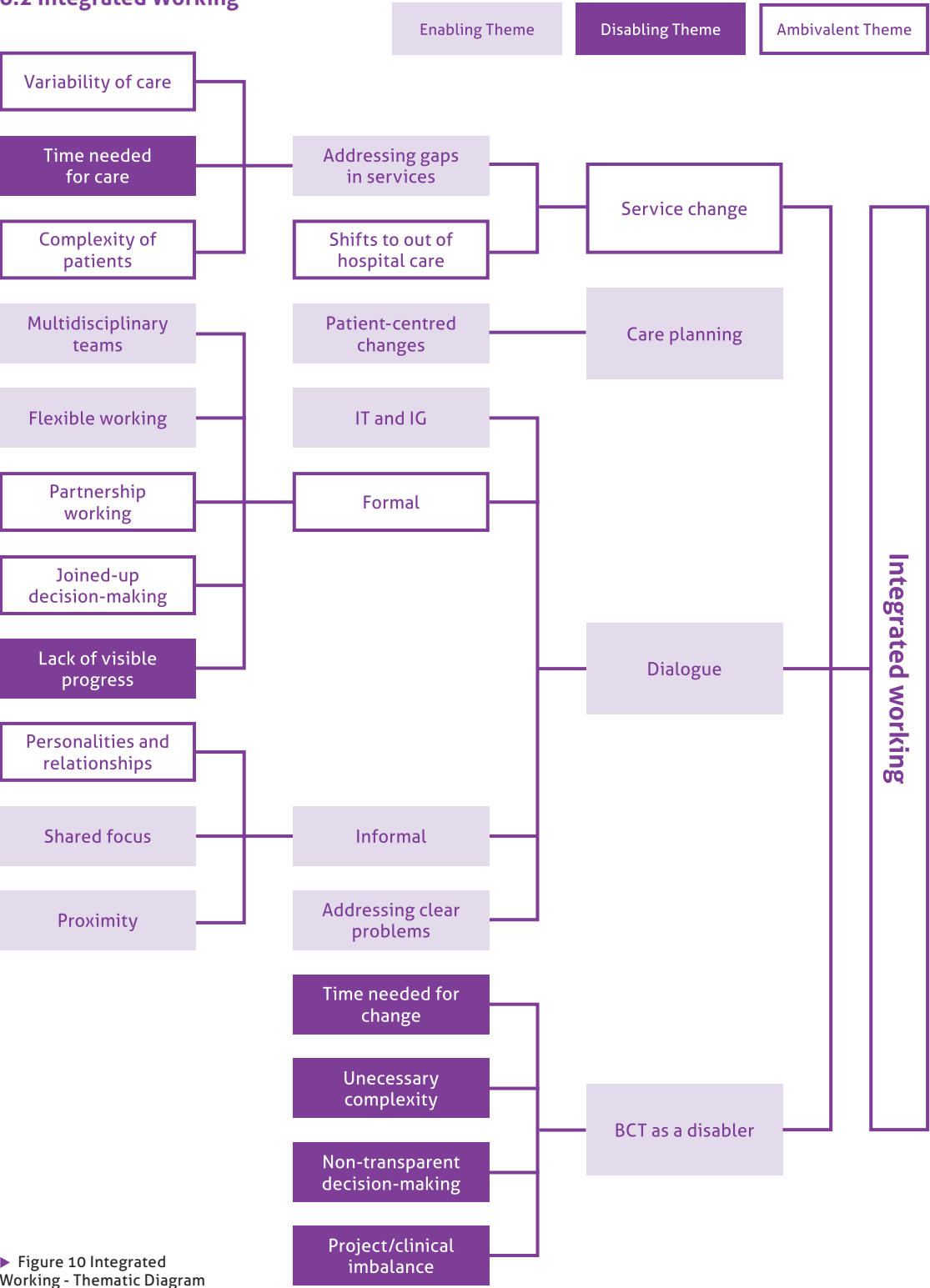
As noted in Chapter 1, a full review of all changes the vanguard made is not possible for a number of reasons; not only would the scope of the evaluation always be limited by time and resource, but the scope of BCT itself under-defined, as noted above, and the specific vanguard inputs were not clearly identifiable. Nevertheless, it was notable that, even with a wide-ranging data collection strategy, the responses of participants reflected a number of very consistent themes around the changes being made by the introduction of the NCM. A fuller discussion of some of these themes is given below in Chapter 9.

The key changes being made within the vanguard, as participants described them, fell under three main headings: more integrated working across the Morecambe Bay area, the development of Integrated Care Communities (ICCs), and cultural changes (both within and across organisations, within approaches to activities and within citizens). Across the piece, the changes show an emergent picture of a programme in which a number of relatively small-scale pilots have been implemented, often addressing localised problems with solutions built on the assets of the local community and/or local service providers. Where the approach has been more dependent on system change, interventions have typically struggled. Participants frequently cited the length of time it has taken to generate shared Information Governance protocols and Information Technology services which, at the time of many of the interviews, were seen as the main disablers for progressing many of the pathways.

The following sections provide a more detailed narrative of each of these key headings.



6.2 Integrated Working



► Figure 10 Integrated Working - Thematic Diagram

Within the overarching theme of integrated working, the changes participants tended to describe could be captured in one or more of the following:

- Addressing gaps in services within a local area (for example, lack of attention to broader issues which may be affecting a citizen’s health, which current services were not addressing;
- Lack of joined-up work between acute, primary and community services);
- Service redesign in order to treat patients in an ‘appropriate place’, moving certain services that had previously been delivered in hospital to other locations and forms of delivery.

A core context of the BCT programme is the perception of gaps in health provision across the footprint. Participants noted that the starting point for delivery was the inequality in provision of care across Morecambe Bay. In some cases this is due to disparity between localities, due to the rurality of the area; in others it is due to gaps emerging from the complexity of patient needs, and in others still it is due to the lack of community-based ‘mid-point services’ which bridge the gap between primary and acute care and prevent symptom escalation.

We know it’s a service that’s needed because these patients are very complicated. Some are very complex and need a lot of input. Ten minutes, a fifteen-minute call from your GP isn’t efficient really, is it? (INT048)

It’s about recognising that there’s a huge variability in both paediatric and maternity practise across the patch. (INT001).

These needs were similarly reflected by patient groups (see Chapter 8), who all raised the variation of care across the geography of Morecambe Bay, and that complex issues required more time with service deliverers, and sometimes alternative approaches to wellbeing.

Not all participants were convinced that they were delivering a ‘new model of care’. The MSK project, for example, was set up to develop an intermediate service to deal with MSK problems without surgery in South Lakes like the one that already existed in North Lancs. In this sense, it was about introducing equality of care into the area.

The basis of the scheme is to introduce what basically doesn’t exist at the moment, which is an intermediate service which lies between the trauma and orthopaedic service and the physiotherapy service. It’s in-between. It’s the muscular-skeletal service. So, it’s a gap in the market if you like. Currently in South Cumbria, we don’t have access to those skills...So, it’s not a brand-new model of care. It’s quite common in various guises elsewhere in the NHS... but it’s filling a gap in the market which we don’t currently supply. (INT039)

The ophthalmology pilot, meanwhile, was set up in late 2016 based on work that had been underway for at least 18 months building on earlier local work. It allowed patients with cataracts and ocular hypertension, plus some paediatric patients, to be seen in the community by optometrists in their private practices.

In the past when we’ve looked at service redesign, and I’m thinking nationally not just locally – very often we look at it as where our bit of the pathway starts...This model allows us to look at the patient journey from when they are first identified, out in primary Care, back out into primary Care. It’s a patient centred approach and allows the clinicians to better work together across the organisational boundaries. I think that fits nicely within the BCT way of working. (INT042)

In areas where the commissioning structures already allowed this kind of work to take place, change was considerably more straightforward than those where organisations did not have ready-to-hand structures in place.

It's supported by the contractual model that they've used, in that lots of these services are commissioned across the country, where community optometrists provide a greater clinical work up, beyond their core contract service. (INT042)

The main mechanism of change that transpired across the data was integration via the creation of Multi-Disciplinary Teams (MDTs), cross-organisation communication and education. Across the region and within different sectors of healthcare, participants reported higher levels of inter-organisational collaboration linked to operations of BCT. While many of the impacts of these were based on anecdotal evidence, participants suggested that integration efforts have been associated with more joined up service provision, shift of care to the community, and patients engaging less with acute and non-elective care and more efficient use of resources.

Across all work-streams, frequent interactions between professionals from different fields has provided an opportunity to gain better understanding of individual roles, responsibilities and service developments, as captured below:

We've started, doing some joint GP consultant clinics...the consultant has actually come out into the community, done the clinic in the GP practice...had a feedback session with the GP afterwards to discuss those cases. (INT001)

One of the good things that has come out of BCT...you've had a lot more meetings of clinicians, across the organisation[s]. So you have a lot of GPs who have managed to meet with the acute clinicians, and it's reassuring to know that you all think the same way, in terms of providing care for people in appropriate settings. (INT025).

We're all working together much more closely. (INT001)

One of the ICCs did quite well in relation to the initially agreed outcomes and KPIs, is the East ICC...it's because they have developed what we call the Multi-Disciplinary Team approach. So, they have got virtual MDT meetings on a day-to-day basis...led by one of the GPs and the Case Manager in that ICC...they talk...And they're able to mitigate the impact of multiple intervention by various teams. (INT062)

The main mechanism of change consistently identified in the Women and Children's Services workstream (WACS) has been system integration with multidisciplinary partnerships that appear across all professional levels of healthcare settings. Participants representing both the clinical and commissioning sectors provided numerous examples of multidisciplinary partnerships, that include but are not limited to:

- Liaison of GP lead with local ICCs, community-based children's nursing teams and acute Trusts to review and divert unnecessary referrals;
- Partnerships between paediatric consultants and GPs in provision of specialised services in a community setting and collaboration of paediatric nursing teams with acute Trusts, public services and third sector to manage children with complex needs outside hospital care.

However, BCT has not been a discrete entity in this sense; participants report there have been attempts to extend professional networks beyond BCT partnerships to facilitate system wide transformation and support embedment of BCT processes into mainstream service provision (for example, linking with Children's and Young People Emotional Health and Wellbeing Transformational Programme).

Consistently across all workstreams, the data collected illustrated the main enabler of multidisciplinary partnerships as their development across multiple levels of workforce relationships, underpinned by shared values and understanding. Participants from the commissioning and provider sector identified that the main values of partnership working were enhanced professional competence, increased opportunity to share knowledge and experience, facilitated communication and decision-making.

I think it fits BCT really, really well because it is a completely different way of integrated working with community providers. It gives patients a lot of opportunity to be seen in the community rather than at the hospital. For this group from the start, we've really had a systematic approach to this, which I think has worked really, really well. So, we had a group of people together looking at what we could do differently for our patients, who could do what, and really being able to put organisational boundaries and any organisational impact to one side, while we were doing all the planning. (INT030)

At the same time, the layers of complexity that this kind of working can introduce was not welcomed by all participants. For instance, across a number of staff grades participants expressing 'frustration' with BCT and its complex processes for lack of continuous progress. This is likely to put strain on the relationships between key stakeholders, having impact on cross-organisational partnership and engagement at the individual level. For example:

They [Blackpool provider] get very frustrated with us, because they can see what needs changing, but there's so many different partners that have to be engaged in Morecambe Bay, it makes it really, really difficult. (INT019)

As the Ophthalmology pilot was rolled out though it was still seen as positive there were some issues with the community based optical practices being private which were overcome by focusing on patient care and what is in it for the practices.

It's created interesting challenges as well, because obviously, Optometrists generally operate as private enterprises, which again isn't normally part of the NHS family. They come at it from a different perspective to some extent as well, so for them it's more extending their business. That led to some interesting discussions. We kept getting it back to the focus of, "This is better for the patient and needs to be accessible to the patient. How can we ensure that's going to happen?" (INT030)

Conversations thus became a key theme for enabling change and overcoming the kinds of obstacles that partnership working could bring about.

Right from the beginning, there's been really good communication and engagement, so when I first got involved was at an engagement event, where patients and other care providers, GPs and the Trust Commissions came together with Community Optical Practise Clinicians...That's how the conversations started, and working from there, there have been regular workshops and communication flow. (INT042)

In certain staffing groups where I've sat in on meetings, it's just been an absolute pleasure, because they're actually chatting away to each other and swapping ideas, and for the ones I've seen it's been really beneficial. There's still, because they are separate organisations, there's still that, are you trying to take my job? Or, are you going to be in charge of me? (INT061)

The thing I've really liked about it actually, more than anything, is improved communication between hospital Doctors and Eye Nurses, and Optometrists, because for years, the two have barely communicated. One of the first things that shocked me when I started working, was how little communication there was between the hospital and primary care. (INT035)

Sitting down together is incredibly powerful and productive. (INT010)

The Advice and Guidance initiative, for example, was seen as a key tool in the enabling of conversations between consultants in the hospital and primary and community care. Both clinical and project leads identified the educational value of multidisciplinary partnerships between consultants and GPs. Increased competency related to partnership working was framed in terms of awareness of capacity and capability across different settings, which minimised unnecessary referrals to hospital. However, data analysis evidences that many of the communication strategies underpinning changes made by the vanguard were far more fundamental than an integrated IT system:

We were blessed in that the Age UK building is next to the hospital, next to the care home and the GPs are in the same building. The communication is awesome. (INT061)

I know our Case Management team in Ulverston...they work really well, but they do work within two GP surgeries that are together in one building, so they're in the building with them. I think that makes for a much better relationship with the GP surgeries. (INT044)

Some premises, you know, they're all in the same building and that's fine...But in many instances, that's not true... [here] all of the GPs are in old Edwardian four-storey buildings that are not DDA compliant. (INT057)

However, while increased communication was welcomed across a number of aspects, not all conversations were considered useful in the long-run.

I'm not really in favour of big GP and Consultant meetings at a corporate level..I don't think there's any value really...My experience of the GP and Consultant meetings...was that you just sit in a room and talk about stuff, which really isn't important on a day-to-day basis, about who pays for what and that sort of thing. That's not of any interest really, to people who are doing the job. (INT023)

If you're talking about the time that people have inputted into the project, it's been very poor use of our time, because this is about the third time we've been around the houses doing the same thing and coming up with the same results. So, a poor use of people's time, which I think will be very costly. On the plus side, I suppose, the more times you go around the houses looking at the same problem, maybe you become sure that what you want to do is the right thing... (INT029)

While this comment points to the need for some of the changes brought in by the NCM to take time to develop and grow, there is also a sense that conversations without a clear sense of direction can be costly in the longer-term. Similarly, participants raised concerns around the amount of talking that was perceived to be taking place:

We've gone to meetings with regard to BCT for several months over the last couple of years, where we've gone there and we've heard exactly what we heard two years ago, again...Yes, there are reasons for that, but then why meet again, if there's nothing new to say? Or why make a plan at one meeting, then have another meeting two months later and forget that you actually made a plan and then make another plan? (INT025)

The extent to which the vanguard instigated and facilitated the conversations was not always clear although the extensive data analysis could identify some cases where the increase in conversations were linked directly to BCT initiatives.

Participants also viewed the vanguard a financial enabler to act upon existing and ongoing discussions taking place 'in the last few years about what we need to do in health care in its broadest terms'. (INT029). This point is salient as a number of participants questioned the extent to which BCT was introducing change when many initiatives had been in development for some time; or, as others reported, BCT was viewed as a hindrance to carrying out longer-term service redesign. There were some negative views, for example, about how much time the integration of care was taking:

About three years or so ago ... we were trying to put some stuff together for the CCG, to try and develop MSK care. That all came to a halt because then we were told, "No, you can't do any more, it's only going to be part of BCT and Vanguard". Then I was one of the project group in the Vanguard project which started, it must be two years ago. X was initially the Project Manager for that and then we had another guy, and now we've got Y... (INT029)

The data shows that other conversations are perhaps more political in focus, particularly around aligning the need for efficiencies within the health system with the shift to a more social model of care. These participants shared concerns about who was involved and engaged with the conversations within BCT, and the effects that representation might have on the overall direction it took:

But also, there's been a change also over the three years, there's been a change in our relationship with the local authority. Not very positively, either. We do struggle -- at the very beginning we got a lot of buy-in, and then I absolutely understand the financial difficulty of the local authority and county council wanting everyone to retreat and regroup and refocus. That changed our ICC to be about a health community, not about a health and social care community. (INT063)

In particular, the relationship between the work of the ICCs and social care was often cited as a disabler that subsequently shaped the development of vanguard work.

I think the only obstruction probably that I've found is the struggle with Social Care. That's the biggest problem, takes up the most time. (INT047)

I suppose you could say our shortfalls in Social Care often mean that we have to deal with admission as well, because there isn't the support to keep somebody at home. I think around here, if Social Care was a better provision, people would stay in their homes more and there'd be less admission. (INT049)

Others, meanwhile, cited an imbalance between staff on the ground and project managers. In this sense, the initiative of integrated care stumbled around the problem of staff recruitment.

There's no difficulty in finding Managers and Project Management people, but there seems to be a huge difficulty in finding people on the ground, Doctors and Nurses. ... You have far too many people who know how to tell you what you should do, but actually no people on the ground to do it. (INT025)

Another theme to emerge from analysis, which reflects this tension between developing distinct, place-based services and wider systematic support, concerns the implementation of specific forms of care plans. These manage key information on patients, but doing so in a way that is patient-centred, respectful and productive. On the one hand, the 'ground-up' approach has been instrumental to supporting the development of this form of care planning:

When I first started doing this job, we had these 10-page assessment forms. They were horrendous, you know: What are you eating? How's your sleeping pattern? Really patronising. [Now] I go in, sit down, have a cup of tea and a bit of a chat and in and around that I'll ask questions which will lead to the answers I need to get. (INT059)

This resonates with activities in other projects and work-streams to work towards documentation practices that will support integrated pathways of care. However, this is clearly time-consuming, and not yet supported by flexible or real-time IT or IG systems: a point which is often cited as slowing or preventing the implementation of some integrated care initiatives.

Once you've done a full assessment of somebody, you have a really good knowledge of how they are and how they function. And also, to prevent hospital admissions, once you can get these care plans in, then if they have a fall and an ambulance rocks up, then they have a really good idea holistically... it helps in their decision making of, do we keep this person at home... or do we have to have a hospital admission? (INT051)

It appears that while staff can see the benefit of Care Plans, they feel IT issues are currently compromising how the plans are shared and agile working has not yet enabled real-time updating of the plans. Data analysis suggests that care plans take time to do and rely upon the care coordinator having the social and healthcare skills to identify need and to get to know patients. A number of care coordinators discussed ways in which they had developed a socially appropriate means of information gathering that observes patient dignity and the contextualised nature of each individual’s lifeworld. This information was felt by participants to be important in enabling a population-based approach that understands local context and need and can tailor interventions to this need:

Now, that’s the difference about population health and well-being, isn’t it, that you’re actually thinking about needs, because you’d have the family assessment there as well. (INT063)

We’re doing a lot with regards to Care Planning and we can’t access the Care Plan unless we go into a GP login and vice versa, to update it. (INT055)

I do agree with Care Planning, but then Care Planning has to be quality Care Planning. You can have a Care Plan, but actually if it doesn’t give us any worthwhile information, actually, will it stop an admission? (INT053)

However, some participants reported tangible signs of change as a result of the care-planning process:

INTERVIEWER: Do you see that the activities that you are involved in are making a difference in care?
INTERVIEWEE: I do, yes. Especially with the Care Planning. We’ve been integral in developing... a new Care Plan template. We’ve been integral in developing this... I feel it will be very important to give NWAS [North West Ambulance Service] access -- especially the evening and weekend service... to these Care Plans. (INT048)

Despite this, the progress of Care Plan templates was unclear at a system-wide level according to data analysis. This lack of clarity is highly reflective of many of the changes which participants reported positively on: once interventions, tools or practices were piloted, it was unclear how these were captured and assessed at programme level. For many participants, this lack of clarity is directly linked to the problem with scaling up interventions which, analysis shows participants believe, is centred on IT and IG.

INTERVIEWER: Do you think it is reducing... hospital admissions, the new way of working?
INTERVIEWEE: I don’t know if it is. I think there’s been issues again with the recording of our data, to determine whether that definitely is the case or not. There’s been a lot of tweaks with how we record our input electronically. (INT044)

So that’s one of the biggest focuses, as well, for next year. Having a common database and the ability to share patient data and referral, will most certainly be one of our biggest enablers. (INT062)

The time that the changes were taking to implement was also a common theme to emerge in participants’ narratives. Typically this referred to how much longer than desirable delivery was taking to implement. A common narrative arose around areas where interventions were implemented on the back of longer-term discussions, existing relationships and partnerships. The Millom ICC, for example, is geographically isolated and has had to cope with the loss of the town’s former iron ore production, which was its main source of employment and income. Participants in the Millom area frequently reported to us a willingness within the community to work creatively and try new ways of working. At the time BCT was initiated, the Millom Alliance was already established, and has been shaped by a clear and urgent need for change, and by patient activism to address this need. On the one hand, this appears to have given Millom ICC something of a ‘head start’ in development but, at the same time, it was recounted that the change in strategy and delivery has posed its own problems for fitting a NCM ‘on top’ of what was already in place:

It is a little bit difficult. There is a lot of overlap, so there’s an overlap with some of the ICC stuff, but also some of the stuff we’re doing is quite different. And we’re probably heading in a slightly different direction to some of what the other ICCs are doing. (INT052)

For other participants, the theme of time simply concerned the length of time change had taken to deliver:

The only thing that hasn’t gone to plan is the computer system, which hasn’t been a massive hindrance, but it would be useful for me to have it there, for me to review the information as it actually happens. ...Now that was supposed to be happening by the end of March, but I’ve just been told that it’s not actually coming in until mid-May now. That’s been a bit of a stumbling block for me. (INT040)

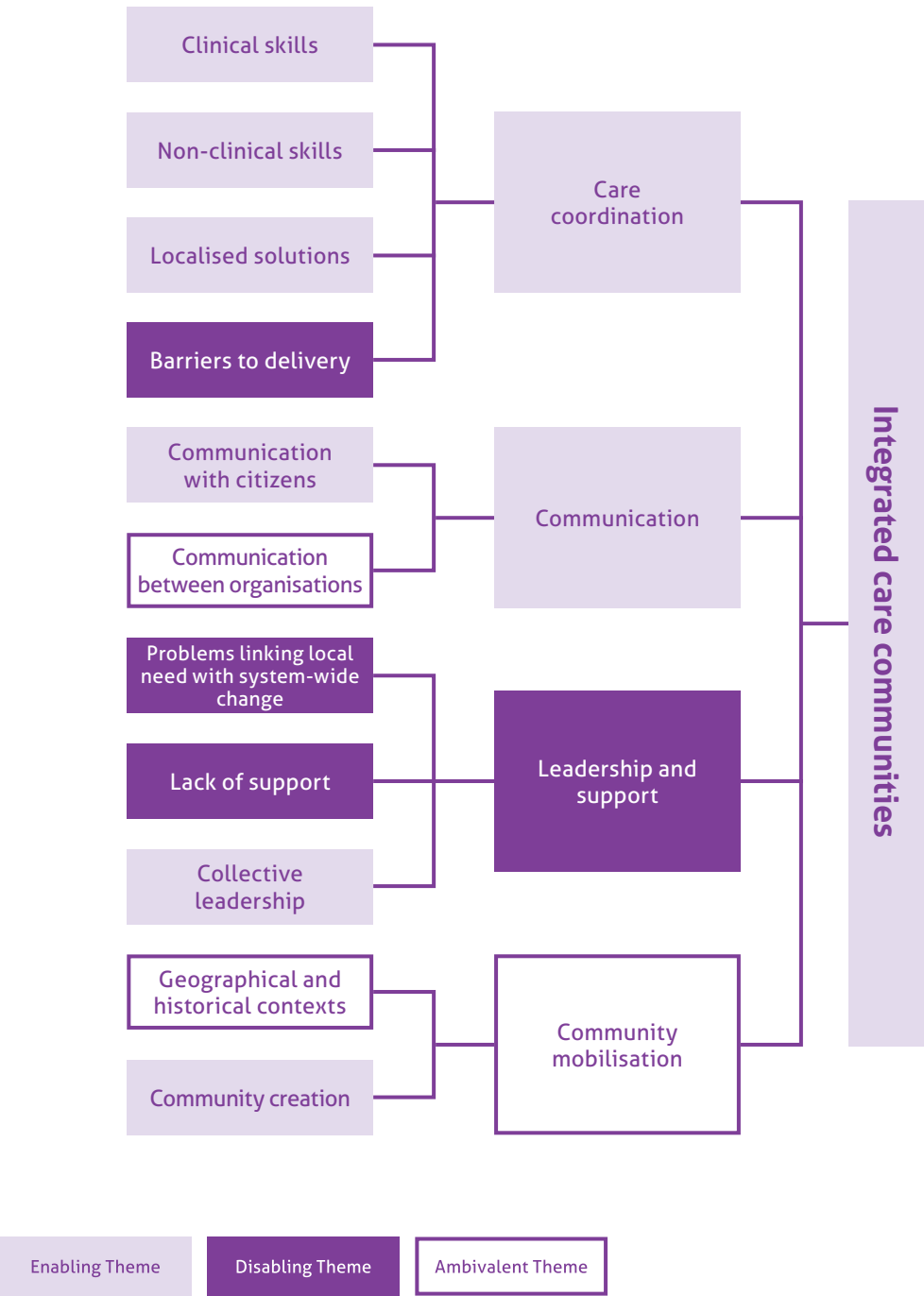
This was linked by others to the commissioning process, and the decision-making timetable:

Unfortunately, with the NHS and with this CCG in particular, ...you find out you have funding for a project, two days before you have to submit the bid, and so basically what they do is write a “back of the fag packet” plan, submit then, hope you get selected. Sometimes you don’t, which is fine, nothing is lost. But if you do get chosen, God help you, because you don’t have a clue what you’re going to do, and you need to start doing it from next week. So, then you have this mad flurry of people trying to sit together and trying to work out ... what it is you’re going to do. ... And by the time you’ve got your act together, there’s two or three months left. And you’re never going to be able to show results. (INT025)

The involvement and relationships between multiple stakeholders was also linked to the time delivery was taking, in particular by participants from primary care. Here, decision-making processes were not considered as enabling well-planned and coordinated evidence-based interventions, which may facilitate change on a deeper level allowing for a social and cultural change. Even in pilots which were reported as successful by participants, some longer-term implications emerged after the initial positive start. For example, in the Ophthalmology pilot:

In terms of Practices, the Optical Practices, some of them have felt their resources strained, because of the sheer number of appointments. They’ve found their clinics filling up and we have had one or two pinch-points in terms of delivery, because patients have tried to get a minor eye conditions appointment and can’t be seen at one Practice, so they try and signpost them to another Practice, who also can’t see them and signpost them to a third, because nobody has any free slots because it’s been popular. There’s been that level of resource difficulty. (INT040)

6.3 Integrated Care Communities



The ICCs are one of the key drivers of the NCM. In terms of the changes being delivered, ICCs are developing at different rates. This can be due to development taking more time, and being more difficult than originally envisaged; the number of meetings required in relation to the time that key partners have to attend; as well as the more structural fact that each area necessarily has different strengths and weaknesses according to the community’s assets, and the staff available:

Each ICC, although we’re trying to run them on very similar models, against a core model, each one will become organic, as you say, and develop its own area of, I suppose, not specialism, but it will be specific to that community. (INT057)

As a result, while changes to clinical delivery (see 2.2.2.1) have reported small improvements which may lead to wider, systematic ones, participants from ICC projects typically begin with the task of widespread cultural change. In this sense, one change that has emerged has thus been the move to a person-centred approach to delivering the ICC strategy. As one project lead puts it:

We’ve not just been growing the ICCs, we’ve been growing people in the ICC to be the ICC. (INT058)

The sense that growing ICCs depends on ‘growing people’ resonates with the theme around the upskilling of staff as part of the NCM programme. However, the tension between allowing roles and people to ‘grow’ from the needs of the community, and investing resource to support this, has been present in a number of interviews. For example, some participants gave clear examples of how additional training supported the implementation of new pathways, and of feeling well-supported in developing these roles. For some care navigators/coordinators, though, there was a view that there had ‘been no support from management. We’ve just been left.’ (INT045). While being left to develop their roles was potentially enabling, where there were related disabling mechanisms – such as a lack of training or support, a regular turnaround of case managers who are in some cases leaving without being replaced, or some key roles were left unfilled – the development of certain ICCs had stalled due to staffing issues.

The care coordinator and care navigator roles were highlighted as key successes in the work of ICCs.

The positives have definitely been the care navigators, and the amount of work they can take on board...It fulfils a need and to a degree it prevents hospital admission...(INT055)

The success of care coordination is frequently linked to the importance of localised practice. The CC’s all appear to have a good knowledge of their locale, services, and the needs of the residents and community, based on the data collected.

I think you’ve got to have a good knowledge of the area, what there is around here. I’ve made myself known... (INT049)

Communication is key...Personally, I’ve tried to network between the primary and acute sectors, going into the hospitals and doing all the things myself. Community mental health, going with the Social Worker. It’s integrating, building up a relationship, getting your face seen so people can put a face to a name, and things like that. Then you get a trust, don’t you? (INT048)

I’ve worked here before for six years before I did this job. So, I would go into people’s houses and I knew them straight away...People are hearing about me. Sometimes the phone does not stop ringing, which is testament to the job itself and the flexibility that I have. (INT047)

Because there was no defined pathway to start with, in some respects we’ve furrowed our own pathway...But that’s one thing I think needs further consideration, is setting us up - how we align really. (INT060)

► Figure 11 Integrated Care Communities - Thematic Diagram

The key to successful care coordination emerged as the building of a therapeutic relationship with a citizen, which takes time. This relationship involved supporting with social signposting, liaising with the Third Sector, hospital appointments, care following discharge from hospital, and arranging appointments; and, for those further embedded within the community, carrying out holistic assessments and avoiding crisis and hospital admission.

If somebody is starting to struggle at home, is starting to just go off their legs a little bit, they've just been discharged from hospital and are socially isolated, or even if the GP is just thinking that they don't look as well as they used to, and they might need just a little bit of input at home. (INT045)

The model of working was thus presented as highly flexible, both in terms of requirements within a single role, and the variations of role across ICCs.

We have to be flexible and we have to develop. Staff tend to develop more autonomously. I have a colleague who is an AP [advanced practitioner]... our OT went on Maternity Leave ... and she was never replaced. So, [name] worked with the trained OTs and... developed her role, so now she goes and she will do the lower level OT assessment...(INT051)

This has raised a number of points around the skills, training and role profile that best suits a care coordinator or care navigator. On the one hand, clinical skills were seen as key to the role:

Moving forward, it would be more beneficial if [regarding employing new CCs] it's someone who has some background experience in health as well as the idea of what is out there in the third sector...a couple that have actually left at the moment... they've come from admin backgrounds...I think they've actually struggled. Whereas we'd look at identifying the risks and everything like that. (INT045)

How they [care navigators] started off was very much non-clinical, but they are actually doing home visits and quite a lot of clinical work. They are also going to be part of putting the personalised Care Plans in place for the moderately frail patients. I think part of my role [case manager] in their support is to try and give them the best skills possible. (INT046)

Whereas other participants suggested other skills were just as, if not more, important: communication skills, for example, were seen as crucial to both addressing some of the gaps in service (e.g. addressing the problems of social isolation, particularly for the elderly), and for liaising between different organisations to ensure joined-up care.

From my perspective, there's been quite a lot of, not sort of, Clinical skills... but the social skills... your communication skills have to be A1, because you're there in that patient's house and it's their turf. (INT060)

[as care coordinator they have] built up some really good relationships on a few of the wards and ring them at least three or four times weekly... you've got to be able to chat to people and cold call...we've built up some really good relationships with the hospital and the third sector. (INT059)

And others who identified project development as a further skill:

I'm doing a lot of project development, which currently I don't think is happening in other ICCs. So there's three things, I'm hospital in-reaching, being proactive in the community with identifying vulnerable people and going out and assessing and trying to help them, then the project side of it to be proactive from a health point of view to prevent. (INT059)

The flexibility of the role posed challenges in other areas, particularly around the similarity of roles to others in social care and the expectations this may give rise to in citizens. As one care coordinator describes:

A lot of the times when I go in, they think I'm some kind of social worker, and I have to explain to them that I'm not a Social Worker. (INT045)

A lot of the stuff the care navigators are doing, that's really social care. ... If social care were just properly resourced in the first place, would we need care navigators? (INT014)

Likewise, defining the success of care coordination is limited by the variation in roles; not just in terms of the locality they operate within, but also their employers and management.

I think that's become apparent with all the ICCs, that we're all different, we're all individual. Every community is different and I think because the care navigator role as well, we've all been differently funded and differently employed. (INT049)

Care coordinators and care navigators emerged within the data as key actors in local successes of the NCM. In many cases, the broad outline of the role allowed them to introduce changes 'upstream' of patients being admitted to hospital:

INTERVIEWER: ... what do you think the key changes are that your role is making?
INTERVIEWEE: Hitting patients upstream... I'm not an emergency service. So, it's about identifying the patients soon enough to put things in place to prevent the hospital admission. (INT049)

Data from and about care coordinators and care navigators highlighted how their role sits at the interface between some of the core strategies of BCTs, their implementation and their outcomes. Many of these changes were 'ground up' in nature, and took on a wide variety forms (qualified nurses/advanced nurse practitioners/non-clinical) which allowed for the testing and refining of integrated care and 'making it work'; often creating impromptu solutions around systems rather than through them. While there were many success stories around the ways in which these roles were implementing change, almost all noted that fitting in a new, somewhat under-defined role caused problems for engaging with other areas of health delivery within the ICC.

And the results of this latest project are showing that it's been really successful. But yes, I really had to battle to be able to do it, because I think that they felt that wasn't my role, yet I hadn't been given a specific job description...that's probably been the only obstruction. (INT059)

The focus on localised solutions enabled a good deal of enthusiasm for the changes the role was perceived to be making; but, as with other areas, tensions emerged between strategic directions and the notion of 'localised practice':

I've struggled with that with BCT, because they've sort of got the heat maps, and it's ooh, respiratory and that -- quite right and they've done some great work, but I've never felt that we have quite managed to join all the dots up. We don't keep going back to say is this addressing the local health needs? (INT061)

There is, then, an emergent tension between the localised delivery of care coordination and the demonstration of its effects, as well as how well it translates across ICCs. This can be illustrated by one care coordinator who captures the benefits of the flexibility of the role, as well as the problem of evidencing it:

My appointments are half an hour, so I've got time to sit and talk to people...from a Mental Health perspective, I suspect that people get seen quicker, they get quicker treatment, they probably have better outcomes. I haven't got any proof of that but I certainly know how many people I see and that it's quite a lot of people. (INT051)

The problem of evidencing change was linked specifically to this emphasis on a ‘ground up’ approach. Likewise, this had raised some challenges for project managers and ICC lead roles in knowing how to steer the development of the teams. Project managers are working across organisational borders and managing newer ways of working that simultaneously fit localised need, whilst also being expected to fit with more generalised and sometimes inflexible NHS targets. Thus, there were some accounts of conflict with staff ‘on the ground’ who are working in flexible ways that may not have been clearly set-out in job roles or where there has been insufficient communication between managers and care coordinators. The data illustrates that balancing the tentative, exploratory nature of the development of ICCs with funding/financial constraints and various IT/IG issues were felt to be limiting some outcomes.

Most of the ICCs are driven by the staff, as in what we call the Core Teams. ...The ICCs themselves don't really have a definitive goal, as such. They've been given the flexibility to develop ideas, ... so it's bottom-up rather than top-down. And that's easier said than done, to a certain extent. (INT011)

On the one hand, a positive view of leadership was portrayed as reflecting a model of collective leadership:

So what I've done is give my team, at whichever level, the permissions. And I've said, "As long as you don't negatively affect the reputation of the organisation, it's not costing us any more money and you have staff working within their professional capacities... then feel free to try it differently... if it does work, then we need to be sharing that positive good working." Because it's agreed as a committee in effect. There's that core team. (INT043)

Try it, to see where you need to improve things or make changes. With any pilot project that's the beauty of it really, that you find out what the weaknesses are and then you try and make those changes. (INT046)

But on the other hand, participant data suggests this did not always result in efficient ways of working. While the ‘try it and see’ approach has been well-received, there have also been problems reported around ICCs going ‘off course’ due to not enough steer. For example, in some ICCs, work reflected the interests of individuals, rather than a population-based approach:

Some of the work wasn't actually targeted, so some of the risk stratification and the kind of identification of the priorities in each of the ICCs as to what particular group of patients they should focus on, hadn't been done. ...The work that was focussed on was very much around particular interests from the commission involved in those groups. And it wasn't necessarily based on population need. (INT062)

Others warned of a lack of sustainability if the ICCs became too detached from the overall strategy:

In order for them [ICCs] to be able to achieve, and for us [hospital Trusts] to be able to achieve stuff, we've got to work closely...otherwise if we're not careful, their concentration will be on something that might make a difference to them, but not a difference to the health economy overall. (INT022)

A necessary tension emerged for each ICC between providing freedom and permission, whilst shaping these with a clearly-defined vision of the programme strategy. However, there were stronger criticisms of the lack of support given to ICCs in operational terms, both in terms of finance and management:

There's definitely been adjustments along the way [to the role]... We didn't really know exactly what we were doing...we've plodded on and tweaked things ourselves along the way and maybe -- there's been a lack of support sometimes as well. (INT044)

*INTERVIEWER: Have there been any obstructions to change...
INTERVIEWEE: ... Not having any direct instruction, but then when I try to do something to make a positive difference, I'm prevented from doing it or not necessarily always prevented, but there's a negativity towards some of the stuff I've been trying to do. But that's more from middle-management, not my immediate GP surgery or my team. Certainly, not from the community. (INT059)*

In some cases, successful changes were identified as happening in spite of a lack of support; but this also raised the problem of how this success might be recognised.

One of our Managerial leads... admitted that she hadn't supported us, but then we've had no support since... I know BCT is more than us. BCT is a big scheme, I'm well aware of that, but – and there's a lot of different pockets of good work going on, but I feel quite chuffed that we've got this far with the Care Plans. (INT048)

The pressure on resources are mainly time pressure; IT not joined up so duplication of information input; and other services such as Social Services and Third sector not always being available or being in communication with ICCs. Some care coordinators reported to interviewers they were experiencing difficulty communicating with hospitals; hierarchical, organisational and bureaucratic barriers appeared to be making this problematic. The two quotes below illustrate that there is perceived to be poor coordination for the discharge of patients, due, in part, to the number of bank staff involved in day-to-day hospital care and poor links with hospital staff.

I think the most difficult part has been our links with the RLI, to be honest. They've got discharge coordinators on each ward, basically. We link in with them and they're really good, but they're the busiest people I've come across... The only other people that I've found it difficult to engage with is the Social Workers in the hospital... I think they thought we were taking their jobs or whatever. (INT060)

If you think about how many bank staff there are in the hospitals every day, working on those wards, that are responsible for discharging patients... it takes me two hours to get to know the patients and know the routine of the ward, just to do the medication round...To then have to think about having to put discharge plans in motion... (INT046)

Interviewees noted the importance of personal relations was highlighted as a key enabler to overcoming these barriers. Such relationships also provided tangible evidence for many participants of change on a qualitative level.

It's been very successful in some parts, particularly where I've got to know a patient in my community that's gone into hospital, if I know them really, really well then I can ring up and say, "I know that patient, that's baseline for them, can they come home today?" And on a few occasions, that has happened, so I have made a difference in for a lot of things... (INT052)

...just the communication from one room to another with the door between, has made a massive difference in the communication between the community Nurses and the GP, but also the hospital. We had no contacts at the hospital at all...now I've been into the hospital and we've got a designated person on each ward. (INT059)

And we're actually building up links with individuals, or teams of individuals, so that you can get things done a lot easier than trying to figure your way through the system. I think that's one real positive that's come out of everything. (INT060)

Alongside the professional links between the ICCs and the hospitals (as well as with other organisations such as social care; see Chapter 7, Section 7.3.2), responding to the needs of the community is a key mantra of the ICCs, and the BCT logic model positions community mobilisation as an input to enable this aspect of the NCM. In some areas, this was reported.

I don't think there has ever been a time when the community has been as involved with the NHS as now. (INT061)

While ‘the community’ was discussed frequently by participants, there was no clear consistency over what specifically constituted the community or its ‘involvement’ (there was notable disparity across the ICCs on how successful ‘engagement’ events had been, which became a matter of some discussion at the 2nd workshop event), and how either of these related to aspects of the NCM such as population-based needs.

One of the most cited examples of community mobilisation was Millom. However, there was a strong sense of the ICC developing alongside and in response to community needs, as discussed above, which were identified from a period of crisis when the area’s healthcare was perceived as under threat. Thus, what was begun in Millom developed from grassroots citizenship: new ways of working emerged from clearly defined moments of threat and crisis, which may be reflected in the roles that have grown within this particular ICC. The nurse practitioner’s role is reported to have developed to be multi-skilled in key areas covering mental health and frail/elderly care. Likewise, the community paramedic’s role is responsive to community and GP need. These two roles are addressing key elements in BCT’s strategy – mental health/frail and elderly, taking the strain off GPs (the paramedic can undertake home visits and can treat lower-grade issues with patients in the surgery setting). Participants from this area highlighted that these developments were enabled by a) community groups being closely involved part of the process, rather than just reacting to changes imposed from above, and b) the mind-set developed as a response to the perceived threat of service closure facilitating a breaking down of some hierarchies and barriers to change.

It could be argued that this is the ideal model for an ICC as it is shaped by local need, context, geography, and its socio-economic base. At the same time, a participant at the 2nd workshop mentioned that Millom is not a ‘real’ ICC as it came from direct citizen action and localised need, and works in collaboration with other organisations. While the roles that have emerged in local practice (such as the community paramedic) align with BCT strategy, other roles specific to the ICC in Millom have experienced a challenging task in trying to fit the BCT template onto an area that has already instigated its own changes and has built its own momentum:

there are all these barriers like systems... I don’t think... we’ve really made any changes. (INT054)

Thus, while community mobilisation provides one set of assets for some of the changes brought about by BCT, it would be unwise to attribute all outcomes of the Millom ICC to one context. While the role of community mobilisation provides one narrative of change, other ICCs have experienced problems in identifying themselves as a clear community, or the ‘clear moments’ where community need emerges:

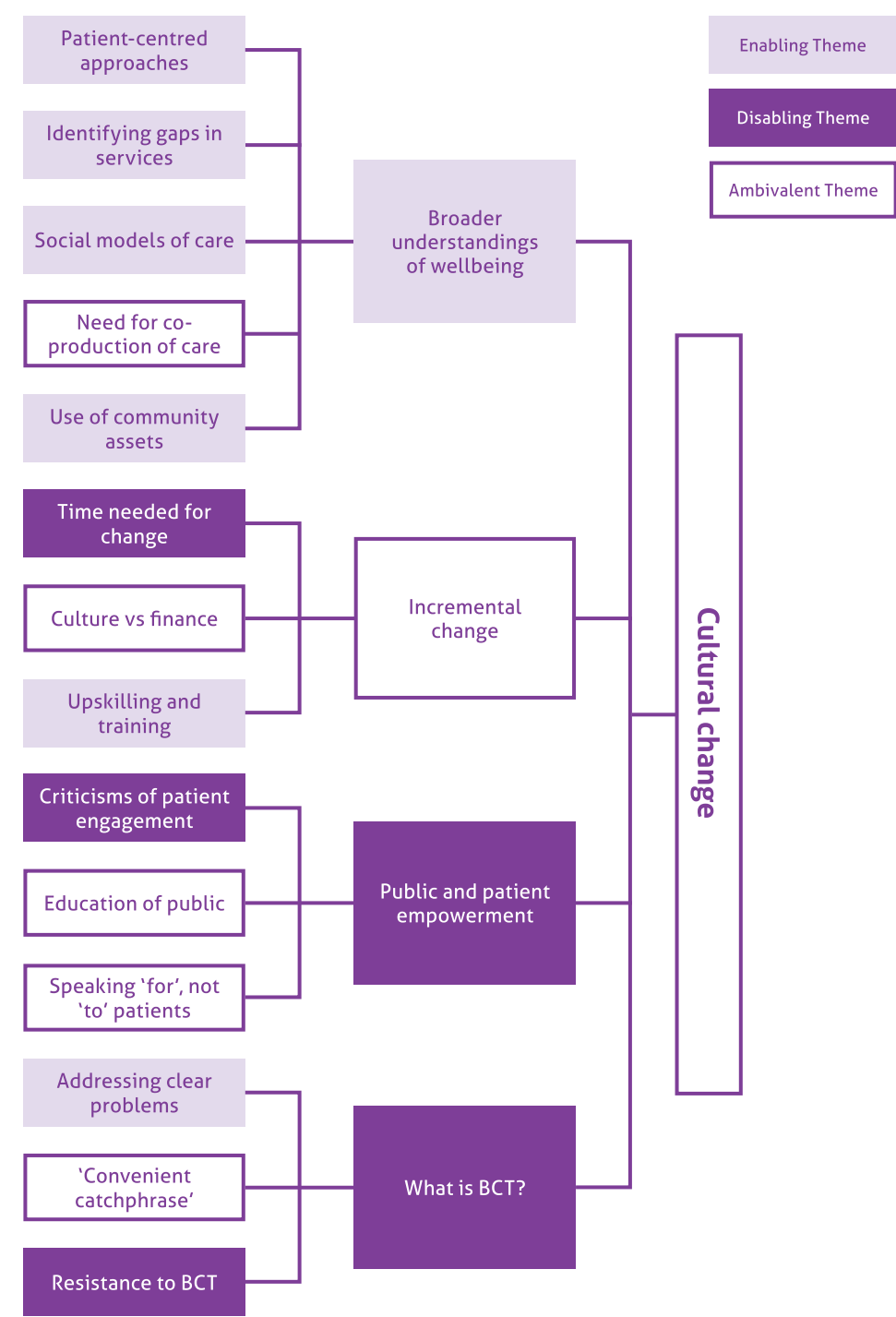
...the public event at East didn’t go particularly well, because there was quite a lot of professional public there. And members of local Parish councils, who actually took offence at the fact that East ICC is five practices who are very dispersed. And they didn’t think it was a community. (INT063)

This is combined with, what appears from analysis, to be some resistance to change from healthcare professionals:

I think healthcare professionals and myself included, find it quite difficult to get their head around not being able to keep everybody on your caseload. You can’t see everybody all the time and be a support for everybody, you do have to try and take a different approach and encourage patients to self-manage. (INT046)

Nevertheless, the East ICC was pinpointed by many participants (across BCT) as a success, primarily due to the willingness of service deliverers to communicate across organisations and utilise data sharing. In this context, where there is no ‘natural’ community in a geographical or social sense, the linking together of the community is dependent upon professional frameworks created by the ICC teams.

6.4 Cultural Change



► Figure 12 Cultural Change - Thematic Diagram

Across both the closer integration between primary and acute care, and the development of ICCs, a key change has emerged as the growing attention to the role that social, cultural, political and economic contexts have in people’s wellbeing has emerged. A number of different interventions and activities are premised on this mechanism for change.

It's a different approach to perhaps coming with a clinical approach, where you've got to go out and do exercise half an hour a day. There are other aspects to being well, other than the physical health. (INT056)

While this is supported by increasing clinical awareness of the ‘bigger picture’ of patient pathways (in particular for patients with complex needs), it also underlies the shift in approach to the overall delivery of care for community roles, such as care navigators:

The question I want to ask people in my community is: What would you like [it] to be, to make it a better place to live and work? So it's not just about health, it's about everything. It's about physical and mental well-being for the whole community, really. Because a happier community is a healthier community. (INT057)

We’ve always been involved with holistic assessment, holistic treatment. We’ve previously been a long-term conditions team, the ethos of the new way of working is treating the patient as a whole, and not just the individual disease or illness. (INT55)

This is often facilitated by patient-centred approaches, which shift focus to ‘individual stories and then improving individual lives’ (INT016):

A lot of patients, social isolation has been a major issue... they really appreciate you talking to them for half an hour. They’ve got things off their chest... (INT044)

To enact this shift to a broader understanding of wellbeing, cultural change was raised as a fundamental aspect of the NCM, most prominently in the Out of Hospital pathways.

Part of it [self-care] is about an understanding of how we change our culture, not just the culture of our population in how they use NHS services, and how do they look after themselves and take responsibility, not just from a lifestyle perspective and how they live, but also in the way they use services and how they comply with treatment etc. (INT018)

The shift to a holistic or social model of care (there was no one model referenced consistently), based on patient empowerment, had achieved consensus across most ICCs.

[We are] trying to educate people to self-care, trying to improve physical health or prevent deterioration ... It's about physical and mental well-being... a happier community is a healthier community. (INT059)

It's about encouraging the community to take ownership and responsibility, to get involved. So, they might decide that having a choir would be good... it's a different approach to perhaps coming with a clinical approach... (INT056)

So the whole thinking behind it is, although loneliness isn't a specific health problem, it does contribute to their overall health and well-being. So therefore, if we can do anything at that stage to guide or signpost the person, to try and relieve that loneliness... their overall health will improve. (INT060)

...one of the things that we’re finding... we thought we were going out to see people with multiple long-term conditions and it might be that... [But] it's more that they live on their own and their mood's a bit low and because they were never a good cook... and therefore they're not eating properly... they're not maintaining their wellness. (INT058)

The data suggested that there is a consensus and understanding about BCT’s focus on population-based health rather than on a deficit model of health. This new way of working aims to address isolation, poor motivation and low mood via ‘social prescribing’ such as lunch clubs, choirs and walking/running groups. It engages with people in their lived contexts, taking a holistic approach through addressing the broader determinants of health such as loneliness, poor diet and inadequate exercise. It is not just treating the individual’s illness, but focusing on their overall health and wellbeing and identifying the influence of local contexts and inequalities – unemployment, pollution, social capital, and the stratification of health outcomes for populations. Via the data collected and analysed, this part of the new model appears to be understood consistently by those implementing it; although it is not always clear what evidence-bases have been used to guide the delivery of services in particular local areas.²⁶

Much of the success of this involves growing the notion of co-production. In the middle of 2017 (some eight months into the vanguard), one project manager reflected on work across the whole of South Cumbria:

I’m quickly coming to realise that to deliver BCT it actually meant that without co-production we were going nowhere. (INT061)

The mechanisms for realising co-produced care are thematically similar across BCT, though often different in practice. In Carnforth, for example, the care coordinator is involved in project development, running cafes for specific health complaints, and the project leads are asking the community what they want as the ICC is developing. This kind of activity was also reported in Ulverston and Dalton where: ‘it’s about encouraging the community to take ownership and responsibility, to get involved’ (INT056). In Millom, meanwhile, community assets such as ‘really good self-help groups’ (INT052) were identified as allowing people to become better educated about illness. As above with population-based health, the ethos of co-production was well-understood; but its realisation was not always tangibly evidenced.

Cultural changes were almost universally described as being ‘incremental’, because they involved both structural adjustments to referral pathways and improved communication with the public around health. As one clinician noted:

Comparatively minor changes in things like smoking, eating, drinking habits, exercise, would have an absolutely massive impact on health care needs – far more than anything that we could do in terms of saving money. (INT022)

The extent to which these smaller changes are able to be linked to visible ‘progress’ on strategic outcomes was a consistent cause for concern for participants, and raised again the problem of which metrics were driving change, and how much these might be focused on short-term hospital numbers:

Actually, you suddenly realise, when you’re working out in the community... people will go into hospital that need to go into hospital... So, I think our lessons learned are, don't just sign up and say, "Yes, I'll reduce those beds," because you might not be able to do that. But what you can do is, you can change the culture, you can change the communication, you can change your processes, you can get rid of waste, you can start to talk to people differently. (INT063)

You can't make culture change happen in one financial year. (INT025)

²⁶ According to Realising the Value (2016), a social model of health combines a deep understanding of what matters to people, with excellent clinical care, timely data and sustained social support (p7).

One theme to emerge from data analysis was that changes in resource use and cost needed to be placed in the context of a broader timescale. This was driven by the understanding that ‘incremental changes’ would add up to larger reductions in cost, but that significant reductions were unlikely to be seen in the short-term, particularly in emergency care:

You have to make step changes before significant improvements happen. So, for example, you could work really hard and reduce A & E attendances by five per cent. That would not enable any change in the number of staff that you need at the front door.... It's one of the biggest challenges to it, is being able to make the step changes that are required to make some of the other things happen. (INT022).

The changes so far have really been more about a mind set of trying to change people's thinking, and appreciate that everyone is just treading water ... so far it's more about the planning and the thinking, rather than the actual, putting it properly, firmly into place. (INT050)

We might not have improved our A & E targets, but do you know what we have done? We're changing the culture towards health and well-being. We're changing models where it makes sense to change models. (INT063)

With my ICC so far the changes so far have really been more about a mind-set of changing people's thinking, and appreciate that everyone is just treading water. But this is throwing people a lifeline and a potential opportunity to make a difference... it's more about the planning and the thinking... (INT050)

Some participants linked this to the problem of the ‘grand programme’ approach to change:

I think if there's one learning point to come out of this, it's about how to manage change a lot more efficiently. One way of managing change is possibly to start not by having some grand project to change the whole of MSK and Trauma Orthopaedic referral pathways, but you actually start with little bits and then pick away at it, so you're gradually developing a new service, which I suppose is what we've ended up having to do to a certain extent. (INT029)

...you can do all these little things that make a short-term difference, and we've proved that we can do that, but it doesn't solve the underlying problems. So, I think we've got a little bit of conflict where, from an ICC point of view and particularly from a CCG point of view... they want numbers and they want proof. Whereas actually, we're trying to... change the way health care is provided in [this ICC]. And that's not going to show itself for five, ten years really. (INT052)

Others, such as one Clinical Governance lead, noted the lack of documentation had been problematic in the integration of care (in this case, between hospital care and private sub-contractors):

I think part of this came down to, they wanted this implemented asap. Everything had to happen yesterday, was what I understood, from when it was launched. Again though, I would say a much stronger training system for the Optical Practitioners would have been a good idea. None of it was terribly complex, but if nobody showed you how to use the computer system, you don't know how to find out where your invoices are raised, and which patients you've been paid for, then it gets stressful for people and that's what I end up dealing with a month or two down the line. Essentially that could all have been dealt with by a properly written training document. (INT035)

However, it appears that tensions arise between the available reporting metrics and the local community’s notions of improved care. The mechanism for change, in such cases, has involved project managers having to manage these expectations without damping enthusiasm:

Their definition of ‘improved care’, for them, or ‘improved patient experience’, is not necessarily the same as the definition of the metrics that we’ve been given that we need to provide. (INT054)

Further discrepancies emerged between patient participation that merely involves information exchange, and true engagement based on meaningful involvement, equal and reciprocal relationships with shared meaning and mutual understanding that leads to transformation of culture with change on both, attitudinal and behavioural level.

For instance the ICCs have picked up on, “we must engage with the community”, but they’ve gone off having conversations rather than engaging with the community. There’s been an interest in doing it, but a lack of real knowledge of what they’re trying to do, or want to do. There’s still that, “We’re going to hold an event and we’re going to invite the community to come along, and we’re going to talk to them. We’re going to tell them what we’re going to do and we’re going to ask them what they want to do.” ... That’s fine if you want a patient participation group, but that’s not community engagement.” (INT018)

The concern with changing the culture of the public regarding their views of local health provision was clear, and many of the intended changes of BCT thus involve proactively working with at-risk populations ‘to empower them in decision-making now’ (INT002). However, how this decision-making is enacted is not always clear at the current stage, and neither is the extent to which proactive interventions and activities are being successfully rolled out. But whereas the notion of holistic care was discussed relatively consistently across staff, the notion of engagement and empowerment was less straightforward to discern.

One of the areas that I think we need to look at is the patient engagement. There has been quite a considerable amount of patient engagement already, but it really is around when you’re redesigning a service, and certainly when you look at the minor eye condition service, which is demand-led, we need to somehow educate patients to turn up to the right place first time. ...Now we’ve got a service in place across Morecambe Bay, we need to make sure that we get a message out to patients so that they know where they need to turn up, so that they get the care they need. (INT042)

Here, the language of engagement is equivocated with the language of education. In some areas, basic education was seen as the quickest route to addressing unnecessary ED attendance:

What we found is... that young people and families do not know basic first aid. So, there’s people coming in with nosebleeds... If we can educate young children for the future, and say, “Actually, you know what, go to the Pharmacist. You don’t need to go to A & E.” (INT043)

One of the examples that we’ve got... are the sick plays... they’re going into schools or community areas and they’re doing a play called Big Sick Little Sick, and it’s about educating particular year groups...about when it’s appropriate to go to the Doctor, the Pharmacy, A & E and when they can look after themselves at home. And the hope is... the children will then go home...and educate their parents, indirectly, about when they can use A & E, or not. (INT056)

However, the tensions between these areas – engagement, education, co-production and empowerment – were apparent across the data. In general, the need for all four aspects was seen as crucial, but how they fitted into the development and delivery of the NCM was not always straightforward or clear. A majority of participants agreed that the key longer-term change was in the public perception of the health service; but how that was to take place, and what the structures for empowerment and decision-making were, or if they had begun to take place, did not present a consistent picture, and was notably often placed in the future tense.

I think what’s happened gradually over the years, people have expected the health service just to provide for them... Whereas, this is about the Clinicians talking to people... it’s getting patients involved in decision making, empowering them to make the decisions. (INT056)

It’s far too easy for some of the patients to call 111, or they call 999 and before you know it, they then hit the front door of the hospital. If we can get away from that and change the mind-set of people...to try and get people to think differently about their own individual health care and their well-being. That actually, if we can then start to get them to use their local resources...then at that point, then we start to see these effects. (INT011)

Given the tensions around cultural change as a mechanism, the number of varying accounts of what BCT actually ‘was’ became a distinctive theme which could both enable or disable change. The need for organisations to come together around a shared agenda was highlighted as the key to many successful examples of partnership working and multi-disciplinary teams. The extent to which such an agenda could be secured seemed to depend on the type of intervention. For pilots which involved structural adjustment – for example, the sub-contracting of services to businesses outside of the hospital – the purpose could be outlined very clearly:

As demand and pressure within the NHS grows, particularly in Ophthalmology with an aging population, it becomes very quickly, very difficult to provide all of the services to all the people, particularly in hospital. As we all know, finances within the health service are tricky at best. So really the whole point of BCT, particularly the Ophthalmology project, is providing an appropriate healthcare system by an appropriate healthcare individual, and that doesn’t have to be a Consultant in hospital. That’s what BCT looks at, the whole pathway, particularly in Ophthalmology about what elements have to be delivered in hospital, and what could be delivered closer to home in people’s homes. (INT041)

But this became less clear the further participants were from the hospitals:

I know BCT... But I’m thinking, “What’s BCT?” From being in the hospital and going on the wards and meeting people, actually you see all the signs, you know that it’s there, but I don’t think it’s trickled down to primary Care. ...Things might change once we go back to being Morecambe Bay. I don’t know. (INT059)

I think BCT has become, it has become a body in itself, and it’s almost like, “This is a problem, but BCT will fix it.” And I keep saying, “But who do you think is BCT? We’re all BCT.” ...And I do think that there’s a bit of friction between the -- and I don’t know who this amorphous blob of BCT is meant to be. It’s become quite a convenient catch-phrase. (INT063)

In some cases, the programme is perceived as government’s latest project that “comes and goes” in the context of severe under resourcing and no perceived effects, which further contributes to wide-ranging apathy within NHS workforce.

I don’t even know anything about it [BCT], very much, to be honest, is the truth. It doesn’t really impact on our day-to-day business. It’s seen a little bit as another one of these initiatives which will come and go. (INT023)

I think it’s lack of information and I think it’s a lack of understanding of what it actually is. (INT007)

In other cases, the situation was more complicated: a care coordinator in East ICC said that they didn’t know what BCT ‘meant’; but was, however, comfortable that they knew what their role entailed, and could describe in terms which aligned to the BCT strategy. In this sense, the reasoning behind BCT may be more apparent than the actual ‘artefact’ of BCT. BCT has been described in more than one interview as a ‘beast’ that although provided processes facilitating change (‘It focused the minds of the key people’), has actually inhibited its scope and pace with its complex structures and bureaucratic procedures.

For example, one participant equated BCT with spontaneous change with a number of processes initiated before commencement of the programme and subsequently absorbed by its operational strategy:

Much of this work, that is under the umbrella of BCT, is work that would be happening anyway I think sometimes, it’s been a little bit hampered by the bureaucracy of a structure like BCT. (INT008)

What we do is being driven by us, it’s not being driven by BCT...We give a good quality of service, the patients...give us good feedback, they find us very accessible and the GPs the same, I think. We’ve had an increasing number of attendances in A & E here, as everywhere else. I suspect we also have more referrals into our outpatient system. But we’ve actually got a falling number of admissions over the last couple of years, as I understand it... But I think some of the work we’ve been doing is contributing to that. (INT023)

In these cases changes were perceived to be independent of the programme, and driven by external factors such as the scrutiny of Morecambe Investigation,²⁷ which has been aligned with the BCT programme’s ambitions and principles. On this note, participants observed that communication about BCT had not been particularly good:

BCT and Vanguard just seemed to appear from nowhere in late 2014 and we all thought, “Where’s all this come from?” That was a bit of a problem. I don’t think that anybody was aware that anybody had applied for it, or at least the people applying for it didn’t tell lots of folk on the ground, at the coal-face. So, it was all a bit, “What is this?” (INT029)

This could result in anxiety both within and between organisations which cemented, rather than changed, organisational ways of working.

I think a lot of hospital staff are potentially anxious, because if you know what we’re trying to do is reduce the bed base, reduce the outpatients’ follow-ups, move things into the community, well, what does that mean for my job? Am I going to lose my job as a result of this? And then you’ve got a great anxiety in the community, where you’ve got people who are working every hour they can, and putting everything they can into their jobs, and they’re thinking, well how on earth can I do more? So, there’s a real anxiety there. (INT006)

In other contexts, resistance was linked to territorialism, such as in the MSK intervention:

The clinical feedback is really good except for one or two GP Practices who stamped their feet and said, “No, we’re not having anything to do with it.” (INT029)

Organisational barriers present a disabling context when, for example, the NCM reaches across different Trusts. Alongside this, working practices in service delivery are often shaped by the disabling context of existing ‘tribalism’ around organisations, or protectionism over roles. A combination of strong professional identity with the climate of economic austerity can raise suspicions over interacting with different sectors of healthcare, particularly for individuals in operational roles who are wary of increases in workload without appropriate resource support. This can affect decision-making and engagement.

There will always be suspicion that you’re trying to either take over, or that they’re going to get the worst end of the deal or whatever. (INT022)

²⁷ <https://www.gov.uk/government/publications/morecambe-bay-investigation-report>

6.5 Discussion and Summary

Overall, the analysis suggests that the most positive accounts of change taking place are within ground-level, localised responses to perceived gaps in services. Changes around improved communication and dialogue between organisations, facilitated by the roles aligned with the vanguard funding, appear to be making important progress in some areas of Morecambe Bay.

This resonates with Greenhalgh et al.’s²⁸ observation that approaches to integration work when responses are imaginative and locally responsive rather than rigid, non-negotiable and driven by technology.

Shortell et al. note there are issues and challenges in implementing the Five Year Forward View. The first is to allow time to build the relationships and cultures that enable GPs and specialists to work together to improve care, ‘sustained effort will be needed to nurture collaborative clinical practice and team working.’²⁹ This is, in many ways, borne out by participants’ accounts of the changes that the vanguard has introduced so far.

Related to this localised activity, participants highlighted the need for ‘incremental approaches’ to change. It was, however, less clear within the data how these map on to the larger-scale changes in the logic model.

Participants suggested that current reporting measures were currently not accurately capturing valuable changes occurring at ground level.

- As such, there is a gap between the organic, site-specific development of ICCs and the expectation for statistical data that will reflect improvements which, realistically, may take much longer to develop.

Incremental changes were described in terms of the larger outcomes which should emerge as a consequence in the future (e.g. reduction in ED attendance). This was evident in the number of participants who described mechanisms in terms of more aspirational than tangible outcomes, or comments about it being too soon to see real change in the system. However, these incremental changes are also outcomes; and can constitute evidence of visible progress needed to propel the programme forward.

- These changes are largely recorded in small-scale interventions and anecdote. This is valuable evidence of change, but needs to be embedded within larger structures of change where it can be scrutinised. Otherwise, it can be limited to ‘good news stories.’
- For example, without an analysis of the non-financial resources and existing community assets employed used, there are likely to be problems with rolling out small-scale pilots to the wider area using clear, contextually aware timescales for delivery.

The main obstacles to change were thematised as:

- Short-term funding and project-based approaches to change.
- The length of time many of the changes were taking to implement.
- The length of time that the machinery of BCT was perceived to require.
- Information Governance and Information Technology.
- A perceived lack of support from leadership.

The main enablers for change were thematised as:

- Successful Multi-Disciplinary Team working.
- Care navigators and other roles which worked flexibly between the ‘gaps’ in service provision.
- Where structures were already in place to support partnership working (e.g. commissioning structures allowing sub-contracting), progress was more straightforward.
- Participants consistently referenced the opening of lines of communication as the main mechanisms for change.
- At the same time, some participants noted that ‘talking’ in and of itself can be problematic if structures do not contain effective feedback loops. There is a question around what one might reasonably expect a certain amount of discussion to produce.

The main gaps in the data currently are:

- Consistent and methodologically robust data collection around incremental change to target populations.
- A wider evaluation strategy to map different elements of data reporting according to strategic criteria for success.
- A more consistent approach to mapping inputs for interventions and activities, along with timescales (based on contextualised factors such as existing community assets and relationships), which can then be compared against outcomes.

28 Greenhalgh, T., Humphrey, C., Hughes, J., Macfarlane, F., Butler, C. And Pawson, R. How Do You Modernize a Health Service? A Realist Evaluation of Whole-Scale Transformation in London. The Milbank Quarterly, Vol. 87, No. 2, pp. 391–416 (2009). P.402
29 Shortell, S., Addicott, R., Walsh, N., and Ham, C. The NHS five year forward view: lessons from the United States in developing new care models. BMJ 350, pp.1-3 (2015). P.2

7 Resources

Evaluation Question:

What is the change in resource use and cost for the specific interventions that encompass the new care models programme locally? How are vanguards performing against their expectations and how can the care model be improved? What are the unintended costs and consequences (positive or negative) associated with the new models of care on the local health economy and beyond?

7.1 Overview

The response to this question consists of two parts. The first shows the results of the health economics analysis of BCT. The second presents the findings from the qualitative data on participants’ use of resources, and unintended costs and consequences on the local health economy.

Overall, this part of the evaluation established that there are many gaps in available data to form a full response to the question. For example, without clear input data, the actual change in resource use was not possible to calculate. The data was also limited in this instance to UHMBT analytics, and therefore the savings and costs to the wider health economy was also not possible to calculate. Underlying this was the problem of many vanguard interventions were slow to deliver, which meant that attributing changes to outcome costs to the work of the NCM is highly speculative.

The purpose of this economic analysis is, therefore, not to provide a definitive answer to the question around costs and consequences of the NCM. Instead, the analysis below serves as a first step in producing a more detailed economic analysis in the 2017/18 evaluation, which will focus on more specific interventions (and their costs and inputs) within the Barrow Town, Bay and East ICCs. As such, the findings of this part of the evaluation form an important step in identifying how the change in resource use of the NCM can be more accurately calculated moving forward, both by establishing output baselines and identifying the key gaps in input data which will need to be filled before a fuller answer to the evaluation question can be provided. This is, in turn, informed by the qualitative analysis of resource use which provides an insight into the different variables involved in accounting for the ‘cost’ of the NCM. The overall findings, and how these can be used for evaluation moving forward, are discussed in the summary section.

7.2 Economic Evaluation

The economic evaluation is based on the metrics developed for the Morecambe Bay Accountable Care System Integrated Performance Report (IPR). These metrics measure key performance indicators for the different workstreams in terms of patient activity. In this report, economic evaluations are given for two central workstreams, Elective Care (formerly Planned Care) and Out of Hospital. The metrics for the Elective Care workstream are Outpatient First Attendances and Outpatient Follow-Up Attendances, the metrics for Out of Hospital are Emergency Department Attendance, Non-Elective Admissions, Non-Elective Bed days and Bed Reduction (ward closures). In order to approximate a measure of cost-effectiveness of the vanguard interventions it is assumed, for the purpose of this evaluation, that intermediate outcomes like lower hospitalisation and reduced bed days for the Out of Hospital workstream and reduced attendance of outpatient appointments for the Elective Care workstream are a positive outcome in themselves, even if the direct link to health outcomes or health savings are more elusive.

For each of the metrics, figures for ‘cost per instance’ have been calculated. For the Out of Hospital workstream these are based on the most up to date figures from the National Schedule of Reference Cost 2015-2016.³⁰ For the Elective Care Workstream, the National Schedule of Reference Cost does not distinguish between first and follow-up appointments. Therefore, in order to calculate per unit costs, figures were drawn from the National Tariff for 2015/16, 2016/17 and 2017/18.³¹ Cost and number of instances have been used to calculate average “cost per unit” figures. Taking into consideration the market forces factor for Morecambe Bay, these then form the basis of cost calculations for the whole of the BCT area, as well as for the three ICCs that have been selected for the next stage of evaluation in 2017/2018 – Barrow Town, Bay and East.

Data from the metrics have then been computed to enable financial impact comparisons on two levels. On the one hand, a comparison is drawn between time periods before and after the onset of vanguard funding and, on the other hand, cost implications are compared based on actual incidence figures versus the calculated “do nothing” trajectory.

The first comparison gives an indication of the impact of the changes already effected through the new care model compared to the same time period a year previously, while the second looks towards the future by comparing the projected performance from the “do nothing” trajectory against the trend indicated by the data since the beginning of vanguard funding.

In terms of timescales, the onset of vanguard funding is taken as October 2016. Year on year comparisons of actual activity are therefore made between October 2015 – September 2016 (‘before’) and October 2016 – September 2017 (‘after’). Comparisons between actual activity and “do nothing” trajectory start with the onset of vanguard funding (October 2016). Trajectories are available up to and including March 2018. In order to maintain comparability of trends between trajectory and actual data (available up to and including September 2017), we calculated the effect of the trajectory as a linear regression of the percentage change between actual and trajectory data since vanguard onset and then applied this effect onto the seasonality of the trajectory. This enabled us to project actual figures forward to March 2018, taking into account how the data is expected to move according to the seasonal effects shown in the trajectory. By doing so, we are able to include trend lines with the graphs, which indicate overall upwards or downwards movements in the data over the indicated periods.

7.2.1 Workstream: Elective Care

The metrics for Elective Care distinguish between Outpatient First Attendance and Follow-Up Attendance, as these are affected by different changes within the workstream and also because they are associated with differing cost implications.

30 Department of Health. NHS reference costs 2015-2016. (2016) <https://www.gov.uk/government/publications/nhs-reference-costs-2015-to-2016>
31 NHS England. National Tariff. (2017) <https://www.england.nhs.uk/resources/pay-syst/national-tariff/>

Outpatient First Attendance

As outlined before, the National Tariff was used to calculate average per unit costs for outpatient first attendances. As new figures are published on a yearly basis, the average per unit cost is different for the years 15/16, 16/17 and 17/18. This has been taken into consideration for the cost calculations.

Average cost per outpatient first attendance: £212 (2015/16); £195 (2016/17); £209 (2017/18).

BCT	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£30,234,990		
Oct 16 – Sept 17	£29,016,021	£29,071,955	-£55,934
Difference year/year	-£1,218,969		

► Table 6 Cost per outpatient first attendance: BCT-wide

Barrow Town	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£2,930,706		
Oct 16 – Sept 17	£2,759,029	£2,855,188	-£96,158
Difference year/year	-£171,676		

► Table 7 Cost per outpatient first attendance: Barrow Town

Bay	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£5,212,472		
Oct 16 – Sept 17	£5,028,558	£5,050,200	-£21,643
Difference year/year	-£183,914		

► Table 8 Cost per outpatient first attendance: Bay

East	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£2,835,432		
Oct 16 – Sept 17	£2,732,300	£2,763,549	-£31,249
Difference year/year	-£103,132		

► Table 9 Cost per outpatient first attendance: East

The Tables show a two-way comparison:

- Down the column 'Cost actual' compares cost differences between the year before the onset of vanguard funding (Oct 15 – Sept 16) and for the first year of vanguard funding (Oct 16 – Sept 17). A highlight in green indicates a cost reduction due to reduced activity, i.e. a reduction in the number of outpatient first attendances. Figures highlighted in red indicate increased cost due to increased activity. Table 6, for instance, shows that first outpatient attendance cost reduced by ca £1.2m in the last year, compared to the year before.
- Across the row 'Oct 16 – Sept 17' compares cost differences between actual cost and the calculated 'do nothing' trajectory during the first year of vanguard funding. Again, a green highlight indicates a lower actual cost than the projected trajectory cost, a red highlight indicates higher actual costs against the trajectory. Table 6 shows that the actual cost last year was lower than the 'do nothing' trajectory by about £56,000.

As can be seen in the tables, all year on year actual costs show a reduction, both for BCT as a whole and in each of the three selected ICCs, due to a real term reduction in first outpatient appointments. Equally, all actual costs in BCT as well as the three ICCs were slightly lower in the last year than the 'do nothing' trajectory.

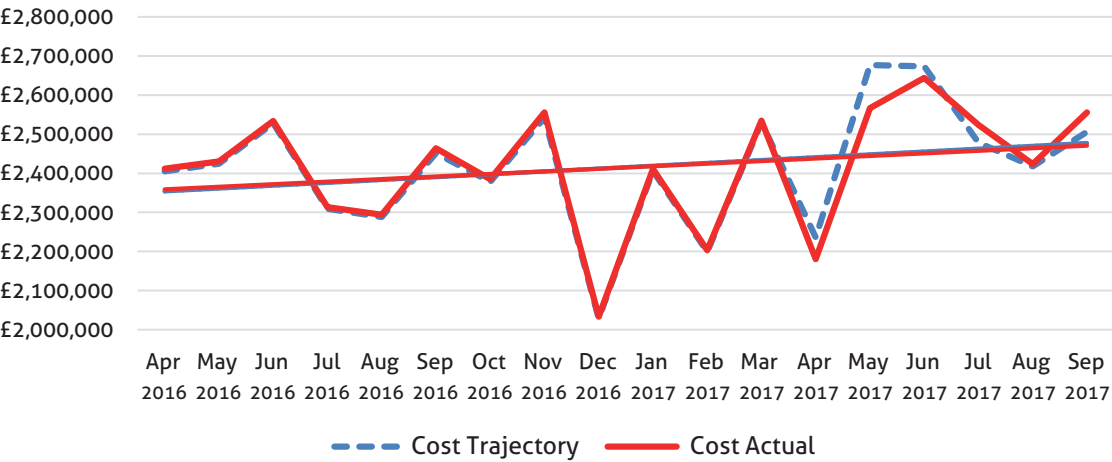
The following graphs (Figure 13 – Figure 19) give an indication of trends within the actual data against the trajectories. For each of the four areas, BCT as a whole, Barrow Town, Bay and East two graphs are presented to indicate trends. The first graph tracks actual data and "do nothing" trajectories from April 2016 – which is the starting point for the 'do nothing' trajectories – to the present date (September 2017) and computes trend lines for both sets of data. This allows for a comparison of upward or downward trends in the actual data against the trajectory.

The second graph looks towards the future and takes the onset of vanguard funding (October 16) as the starting point and includes the projected trajectories up until March 18. In order to make the trend lines comparable, the actual data has also been projected forwards to March 18 on the basis of a linear regression of the percentage change between actual and trajectory data since implementation of the vanguard to account for the seasonality in the trajectory.

Here, a word of caution needs to be issued with respect to the trend lines. While the trend lines are good indicators of whether there is a falling or rising trend to be detected in the longitudinal data, due to the limited amount of data points and the great variation of data within the respective time periods, the trend line should be taken as an indicator of a rising or falling trend only and the degree of incline or decline should not be taken to predict a certain data point on the graph in the future. In addition, there are not enough data points to make any statements about the statistical significance of the differences in trends.

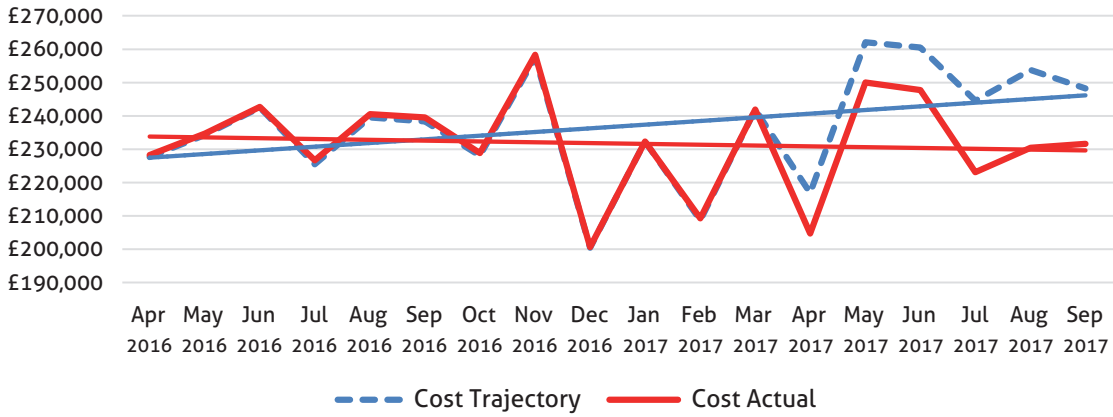
In summary, BCT as a whole has been following the trajectory closely (Error! Reference source not found.3), with overlapping trend lines for actual and trajectory data. This indicates, that, overall, first outpatient appointments have been increasing over the last year. Figure 14 indicates that this upward trend is also set to continue into the next year. Where the three ICCs are concerned, Bay and East are following the same trend as the overall BCT data, while Barrow Town seems to have been able to reverse the upward trend in first outpatient appointments over the last year indicated in the trajectory into an overall downward trend, both in the figures to date (Figure 15) and in terms of future projections.

BCT: OP 1st Attendance cost: actual vs trajectory to date



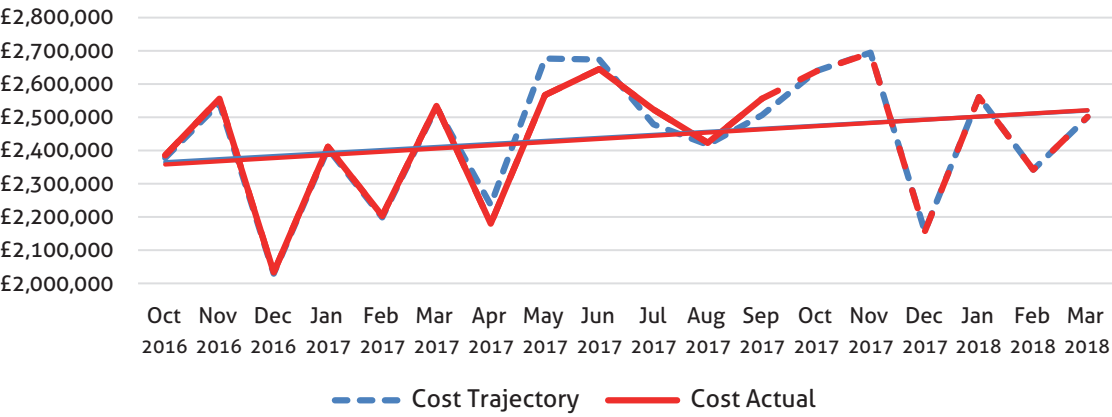
► Figure 13 OP 1st Attendance Cost: BCT

Barrow Town: OP 1st Attendance cost: actual vs trajectory to date



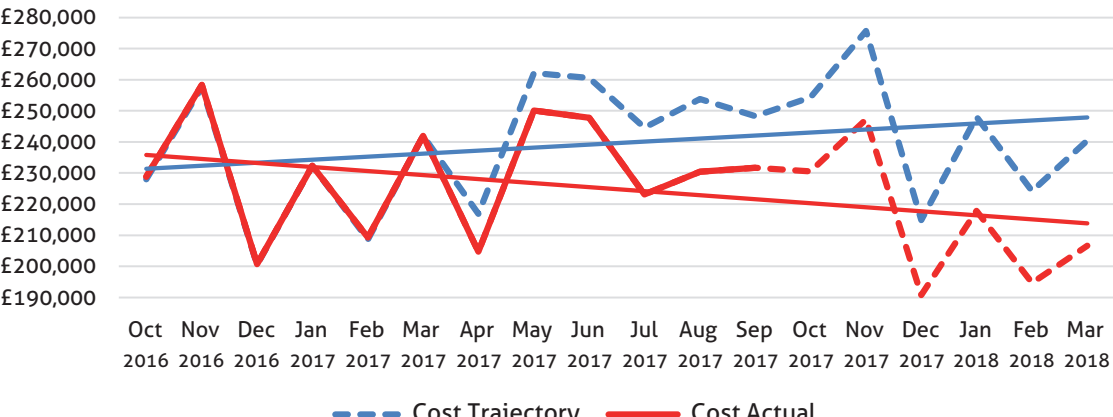
► Figure 15 OP 1st Attendance Cost: Barrow Town

BCT: OP 1st Attendance cost: actual vs. trajectory since vanguard funding



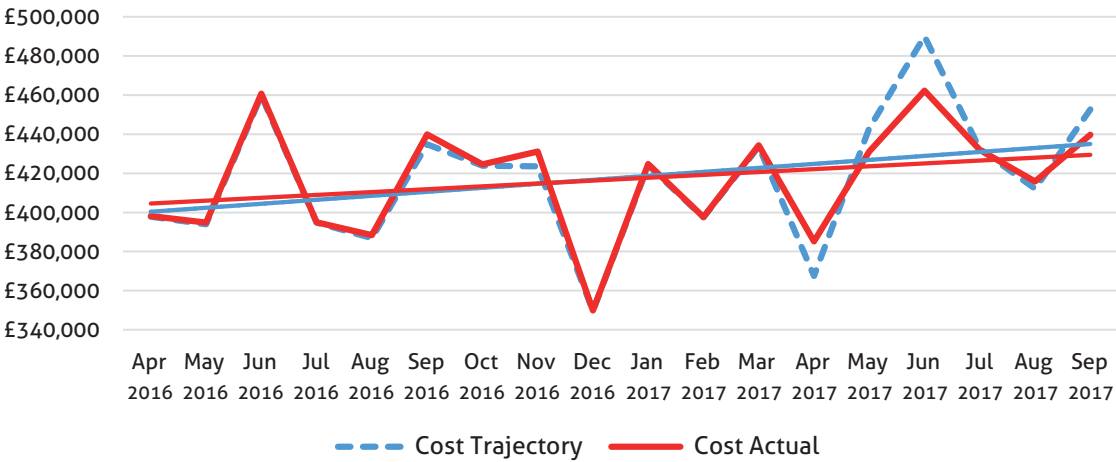
► Figure 14 OP 1st Attendance cost since vanguard: BCT

Barrow Town: OP 1st Attendance cost: actual vs. trajectory since vanguard funding



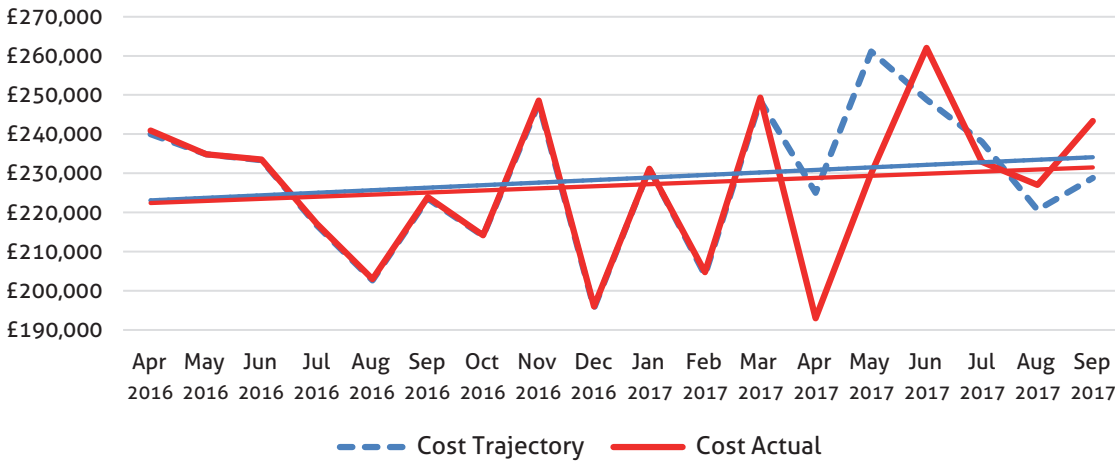
► Figure 16 OP 1st Attendance cost since vanguard: Barrow Town

Bay: OP 1st Attendance cost: actual vs trajectory to date



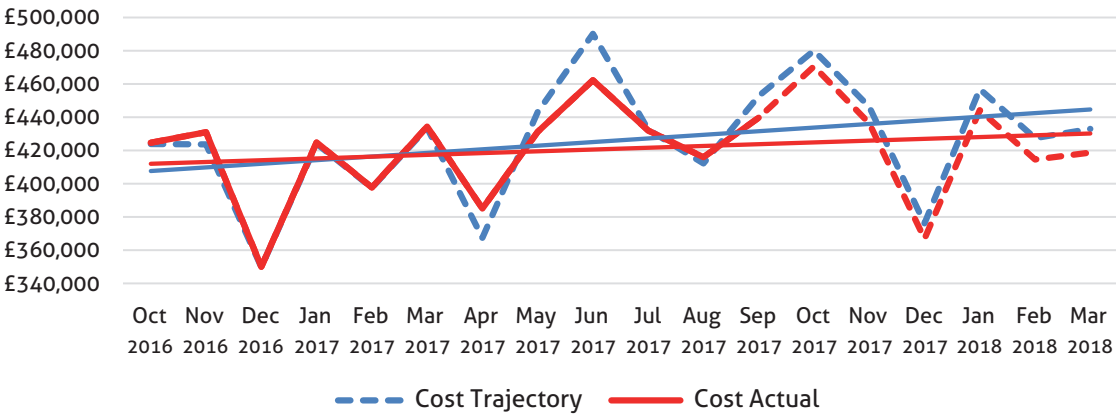
► Figure 17 OP 1st Attendance cost: Bay

East: OP 1st Attendance cost: actual vs trajectory to date



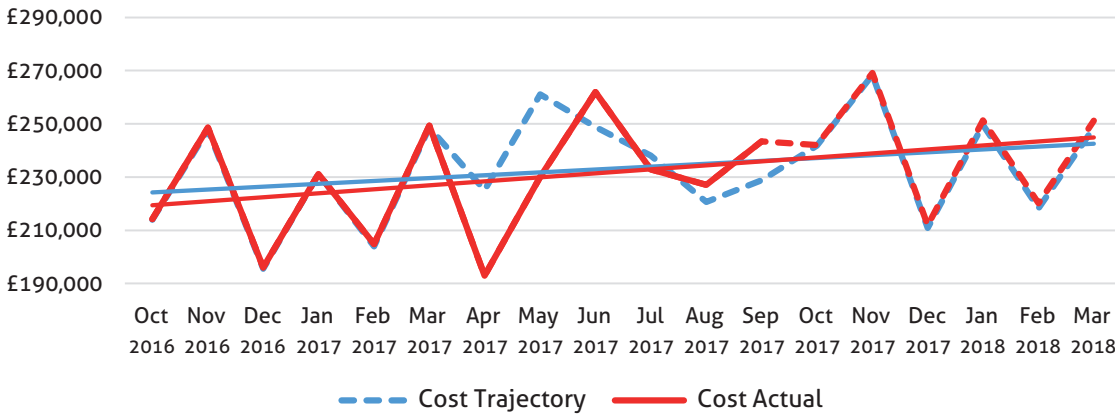
► Figure 19 OP 1st Attendance cost: East

Bay: OP 1st Attendance cost: actual vs. trajectory since vanguard funding



► Figure 18 OP 1st Attendance cost since vanguard: Bay

East: OP 1st Attendance cost: actual vs. trajectory since vanguard funding



► Figure 20 OP 1st Attendance cost since vanguard: East

Outpatient Follow-Up Attendance

In analogue to Outpatient First Attendance, the average per unit cost for Outpatient Follow-up Attendance has been calculated on the basis of the National Tariff, taking into consideration the Morecambe Bay market forces factor. The projected trajectory costs have been calculated on the basis of the 17/18 figures.

Average cost per outpatient follow-up attendance: £127 (2015/16); £117 (2016/17); £105 (2017/18).

BCT	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£42,845,313		
Oct 16 – Sept 17	£39,127,001	£39,000,021	£126,980
Difference year/year	-£3,718,312		

► Table 10 Cost per outpatient follow-up attendance: BCT-wide

Barrow Town	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£4,201,041		
Oct 16 – Sept 17	£3,741,515	£3,777,271	-£35,756
Difference year/year	-£459,526		

► Table 11 Cost per outpatient first attendance: Barrow Town

Bay	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£7,654,135		
Oct 16 – Sept 17	£6,932,742	£6,996,798	-£64,056
Difference year/year	-£721,393		

► Table 12 Cost per outpatient first attendance: Bay

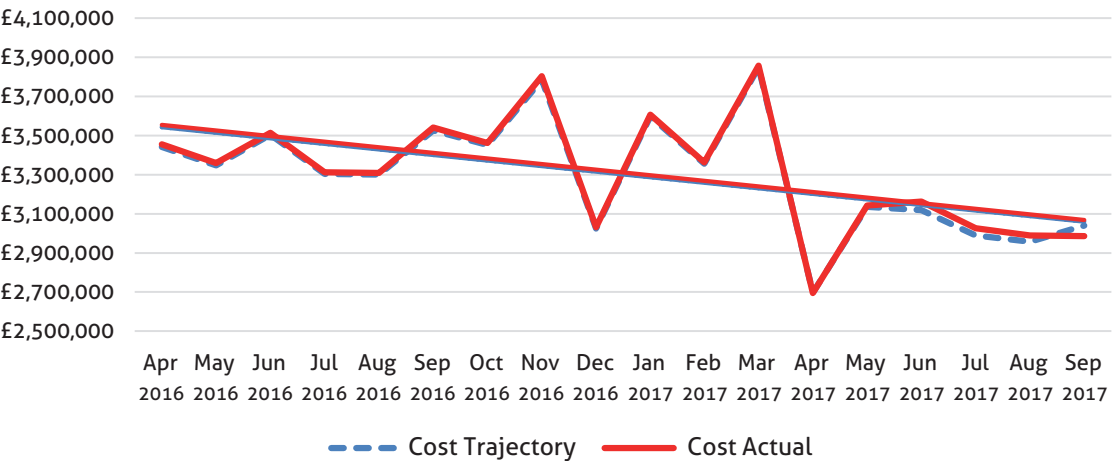
East	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£4,075,128		
Oct 16 – Sept 17	£3,793,473	£3,755,171	£38,302
Difference year/year	-£281,655		

► Table 13 Cost per outpatient first attendance: East

For BCT, as well as all three individual ICCs, costs for follow-up attendance have been reduced considerably (£3.7m) compared to the previous year. It has to be taken into consideration, however, that the unit cost per follow-up attendance is also lower in this year compared to the previous. For BCT as a whole and East, the cost, however, is slightly higher than the predicted 'do nothing' trajectory. Barrow Town and Bay show a decrease in follow-up attendance that is exceeding the trajectory.

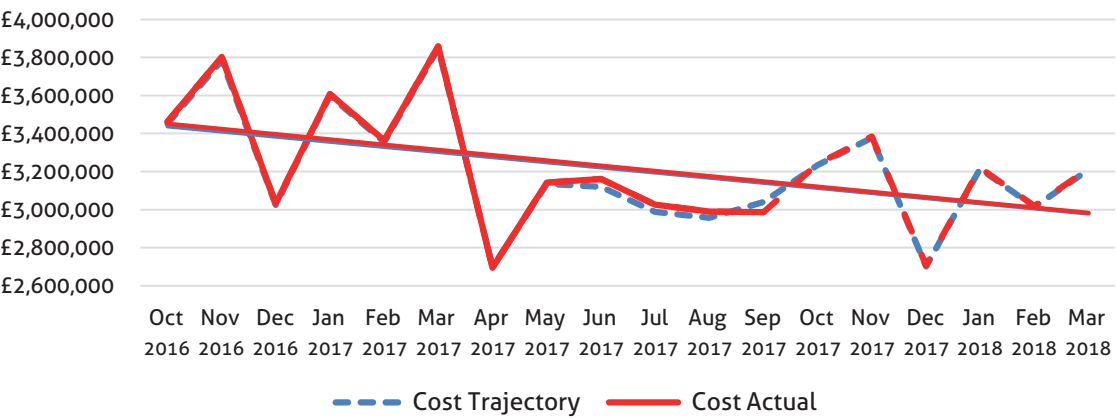
The following graphs also indicate a downward trend for the cost of follow up appointments for BCT as a whole as well as all three ICCs that follows the path of the trajectories very closely. Again, part of this would be due to the reduced unit cost of follow up appointments, combined with a reduction in activity.

BCT: OP FU Attendance cost: actual vs trajectory to date



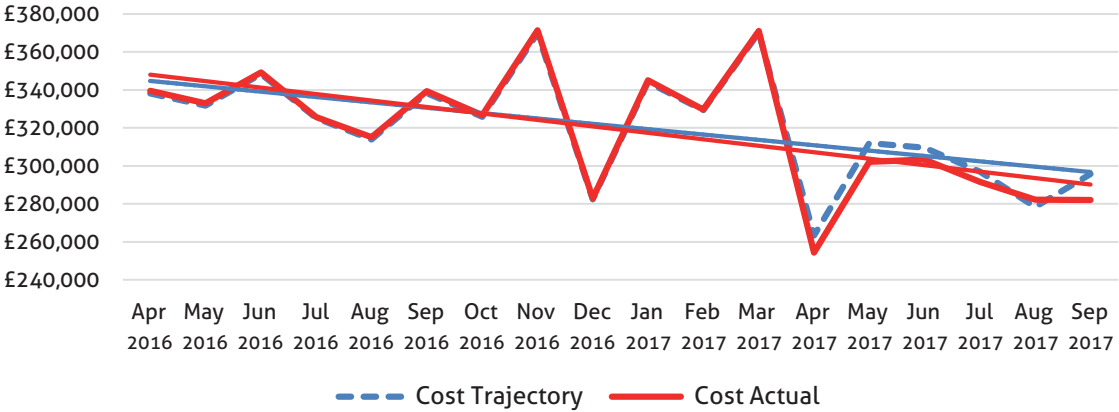
► Figure 21 OP Follow up Attendance cost: BCT

BCT: OP FU Attendance cost: actual vs. trajectory since vanguard funding



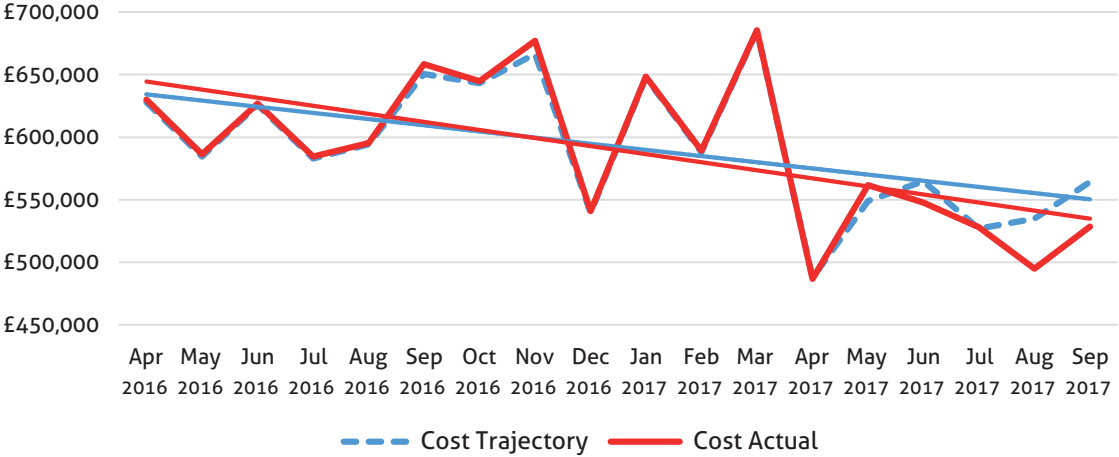
► Figure 22 OP Follow up Attendance cost after vanguard: BCT

Barrow Town: OP FU Attendance cost: actual vs trajectory to date



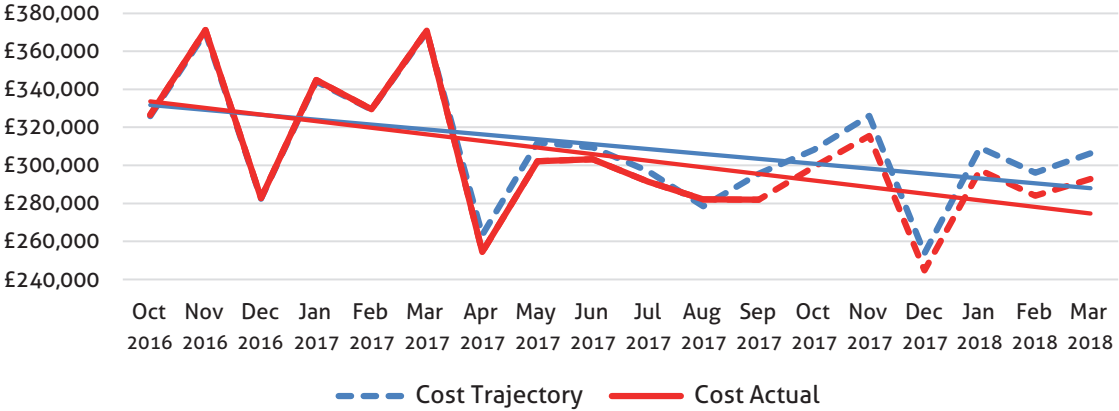
► Figure 23 OP Follow up Attendance cost: Barrow Town

Bay: OP FU Attendance cost: actual vs trajectory to date



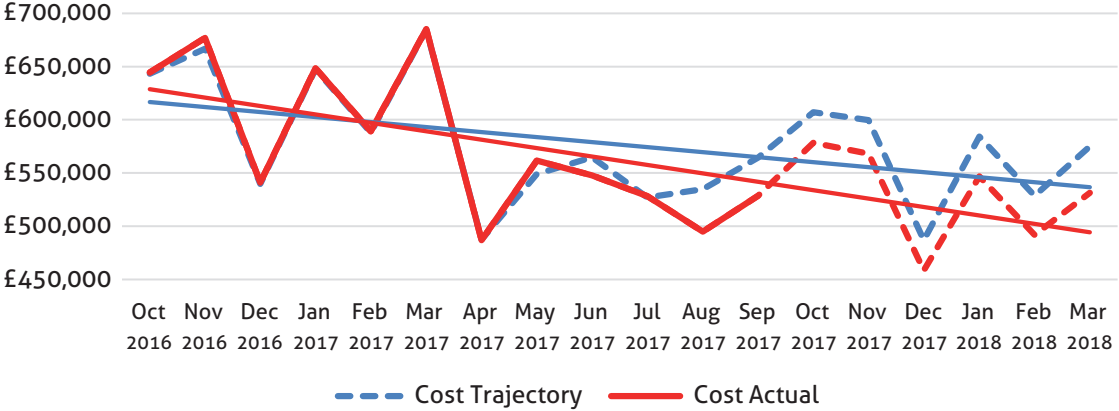
► Figure 25 OP Follow up Attendance cost: Bay

Barrow Town: OP FU Attendance cost: actual vs. trajectory since vanguard funding



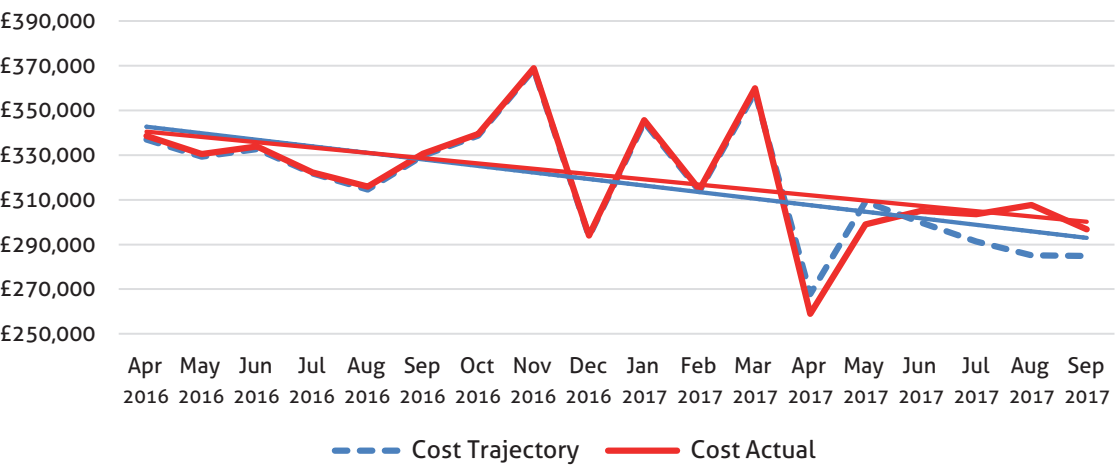
► Figure 24 OP Follow up Attendance cost after vanguard: Barrow Town

Bay: OP FU Attendance cost: actual vs. trajectory since vanguard funding



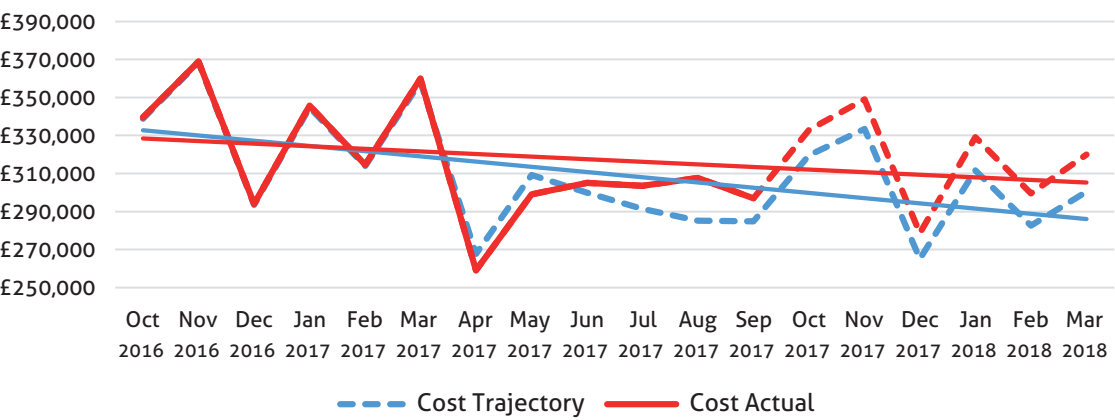
► Figure 26 OP Follow up Attendance cost after vanguard: Bay

East: OP FU Attendance cost: actual vs trajectory to date



► Figure 27 OP Follow up Attendance cost: East

East: OP FU Attendance cost: actual vs. trajectory since vanguard funding



► Figure 28 OP Follow up Attendance cost after vanguard: East

7.2.2 Workstream: Out of Hospital

The metrics for the Out of Hospital workstream are Emergency Department Attendance, Non-Elective Admissions, Non-Elective Bed days and Bed Reduction (ward closures). As with the Elective Care workstream, intermediate outcomes of these metrics like lower hospitalisation and reduced bed days are interpreted as positive outcomes in themselves, even if they cannot be linked directly to changes made through vanguard interventions.

Emergency Department Attendance

The average per instance cost for emergency attendance has been calculated on the basis of most up to date figures from the National Schedule of Reference Cost 2015-2016.³² Taking into consideration the Morecambe Bay market forces factor, the per instance cost is based on figures for emergency departments (National Code 01) only, as this reflects most closely the recorded activity data. This yielded an average per instance cost per ED attendance of £153.

BCT	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£13,914,333		
Oct 16 – Sept 17	£13,300,784	£13,495,337	-£194,552
Difference year/year	-£613,548		

► Table 14 ED Attendance cost: BCT-wide

Barrow Town	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£1,840,338		
Oct 16 – Sept 17	£1,695,100	£1,764,944	-£69,844
Difference year/year	-£145,237		

► Table 15 ED Attendance cost: Barrow Town

Bay	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£2,653,760		
Oct 16 – Sept 17	£2,499,340	£2,557,248	-£57,908
Difference year/year	-£154,420		

► Table 16 ED Attendance cost: Bay

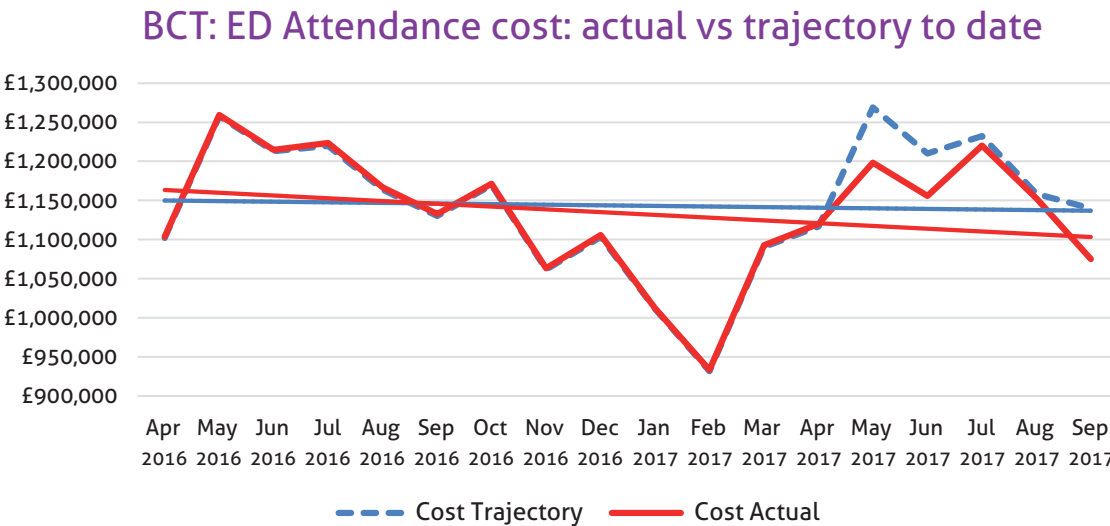
East	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£643,968		
Oct 16 – Sept 17	£616,303	£625,798	-£9,496
Difference year/year	-£27,665	£625,798	

► Table 17 ED Attendance cost: East

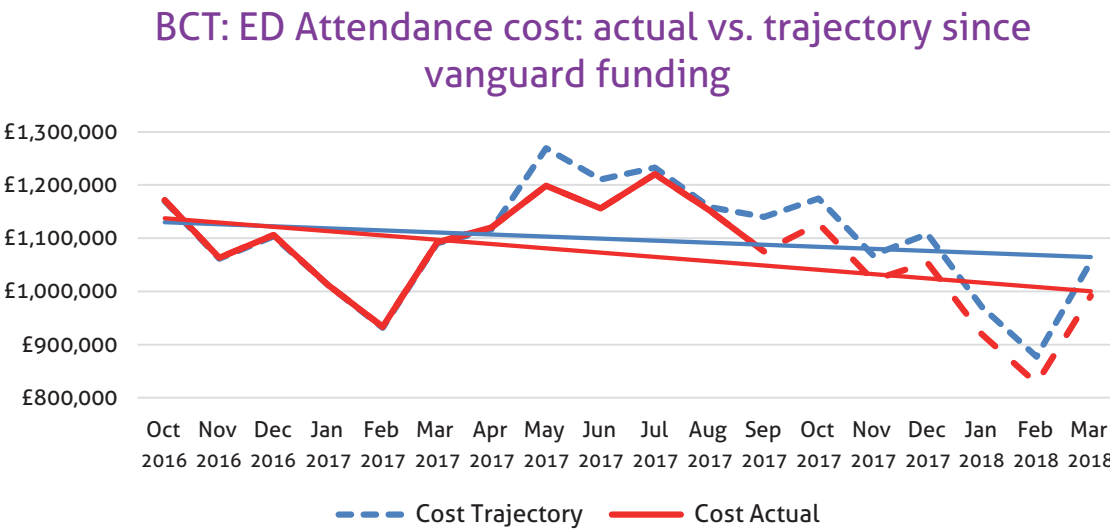
³² Department of Health. NHS reference costs 2015-2016.

All year on year comparisons between 2015/16 and 2016/17 show slight decreases in overall emergency department attendance, signifying improvements in avoiding ED attendance. In addition to that, in BCT as a whole, but also in each of the three ICCs, the overall ED attendance figures were lower in the last year than the 'do nothing' trajectory.

These postive trends are also visible in the graphs comparing trends in the data between actual cost and the trajectory, both to date and when looking at the projected data until March 2018:

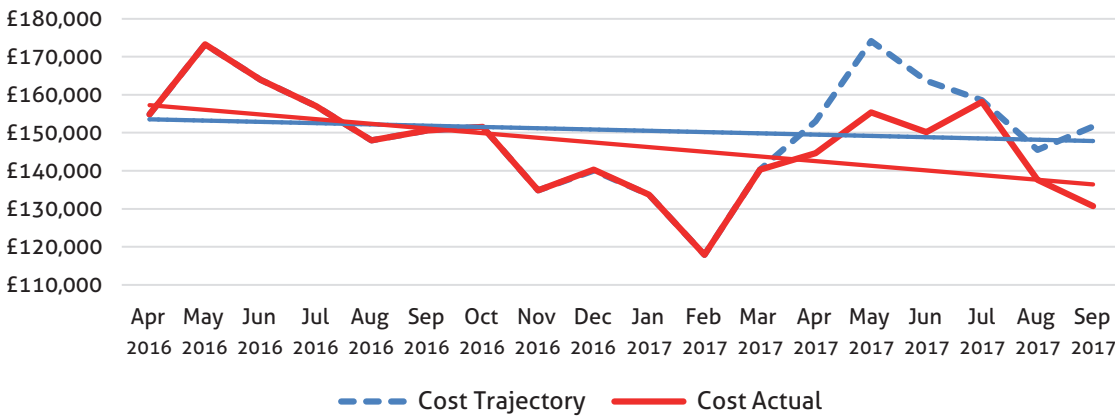


► Figure 29 ED Attendance cost: BCT



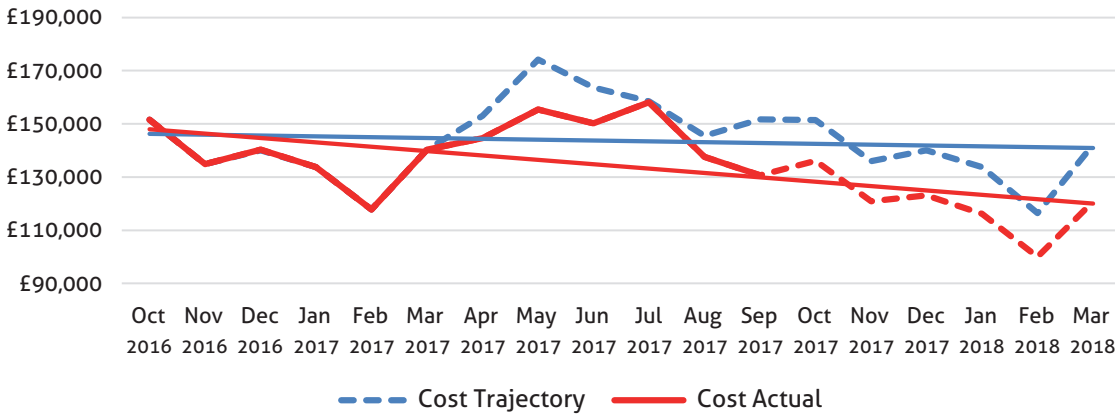
► Figure 30 ED Attendance cost since vanguard: BCT

Barrow Town: ED Attendance cost: actual vs trajectory to date



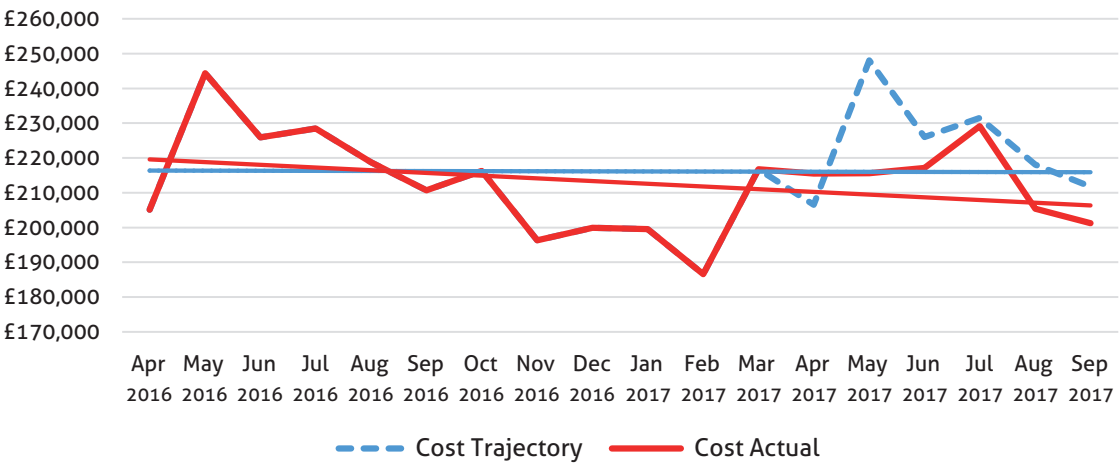
► Figure 31 ED Attendance cost: Barrow Town

Barrow Town: ED Attendance cost: actual vs. trajectory since vanguard funding



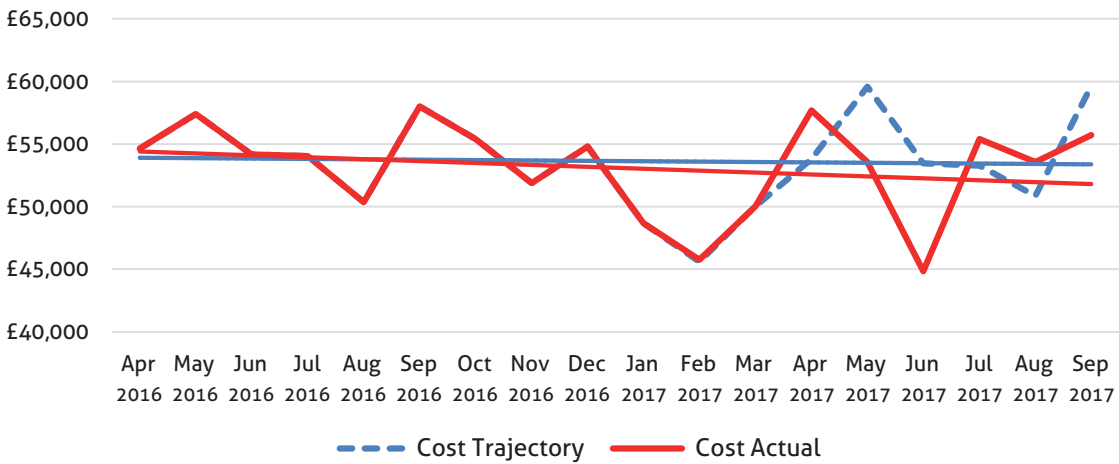
► Figure 32 ED Attendance cost since vanguard: Barrow Town

Bay: ED Attendance cost: actual vs trajectory to date



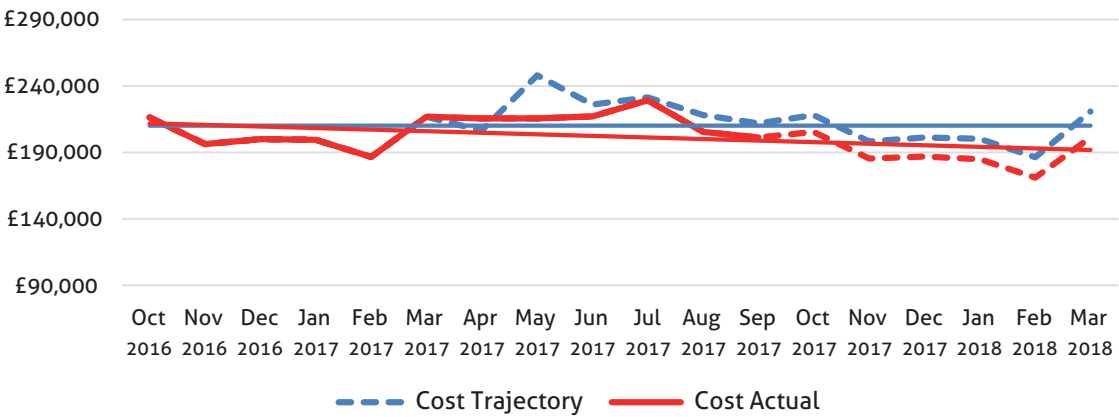
► Figure 33 ED Attendance cost: Bay

East: ED Attendance cost: actual vs trajectory to date



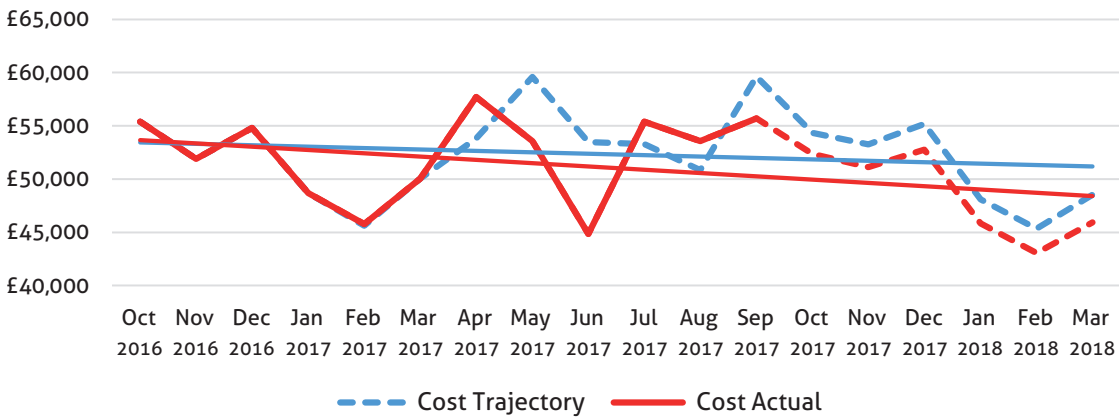
► Figure 35 ED Attendance cost: Bay

Bay: ED Attendance cost: actual vs. trajectory since vanguard funding



► Figure 34 ED Attendance cost since vanguard: Bay

East: ED Attendance cost: actual vs. trajectory since vanguard funding



► Figure 36 ED Attendance cost since vanguard: East

Non-Elective Admissions

Non-elective admissions are defined as unplanned, often urgent admissions (often via A&E), generally understood to include at least one overnight stay on short notice because of clinical need or because alternative care is not available. The average reported spell cost of a nonelective inpatient admission (including excess bed days) from the National Schedule of Reference Cost 2015-2016³³ adjusted for the Morecambe Bay market forces factor is £2,263.

BCT	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£86,459,878		
Oct 16 – Sept 17	£81,062,925	£82,187,813	-£1,124,889
Difference year/year	-£5,396,954		

► Table 18 Non-Elective Admissions cost: BCT-wide

Barrow Town	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£9,827,660		
Oct 16 – Sept 17	£9,313,988	£9,354,414	-£40,425
Difference year/year	-£513,672		

► Table 19 Non-Elective Admissions cost: Barrow Town

Bay	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£17,231,783		
Oct 16 – Sept 17	£15,665,875	£16,172,355	-£506,481
Difference year/year	-£1,565,909		

► Table 20 Non-Elective Admissions cost: Bay

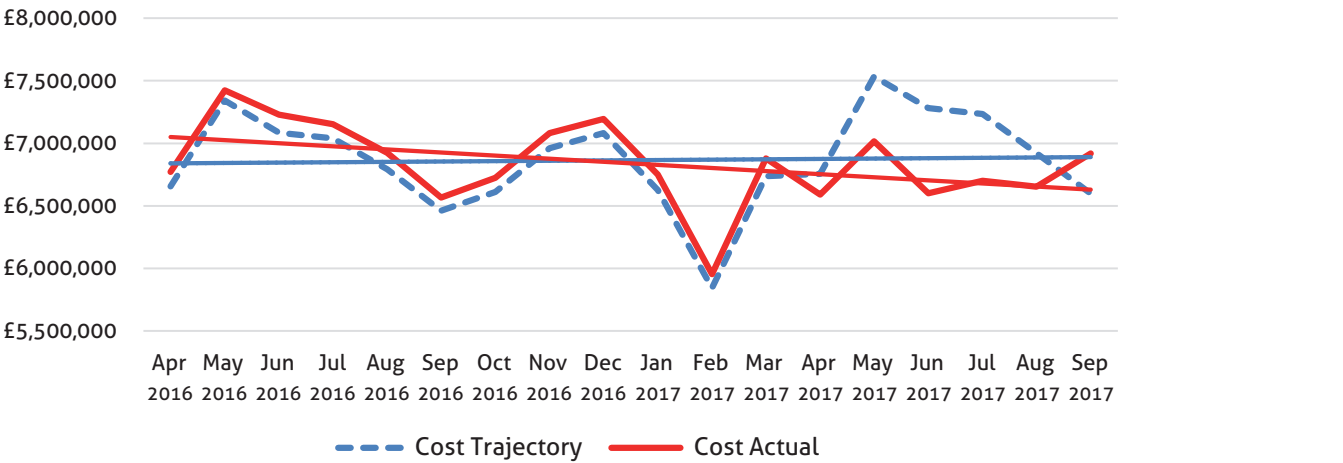
East	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£6,191,222		
Oct 16 – Sept 17	£6,007,930	£6,089,020	-£81,090
Difference year/year	-£183,293		

► Table 21 Non-Elective Admissions cost: East

In analogue to emergency department attendance, figures for non-elective admissions have reduced since vanguard onset compared to the previous year, resulting in a reduction in cost for BCT as a whole of over £5m, as well as considerable cost reductions in Barrow Town, Bay and East ICCs. Again, as with emergency department attendance, the cost of non-elective admissions have also been lower in the last year compared to the 'do nothing' trajectory, with over £1m difference for BCT as a whole.

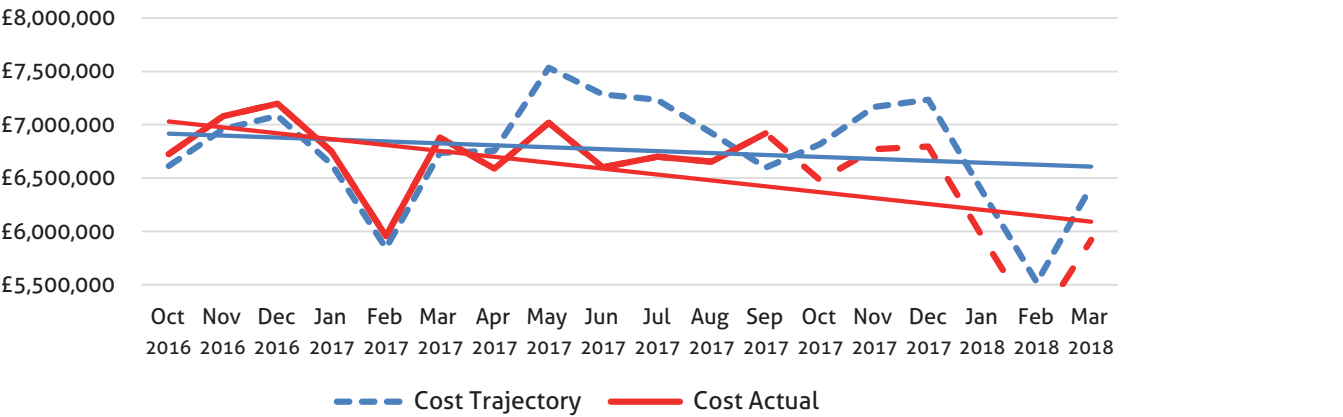
This downward trend is also reflected in most of the trend lines comparing actual versus trajectory up to date and for the projected future costs, as demonstrated in the graphs below. Apart from Barrow Town ICC, where actual costs to date and future projections do not show an improvement against the trajectory, the ICCs and BCT as a whole show slightly better trends than the trajectories:

BCT: NEL Admissions cost: actual vs trajectory to date



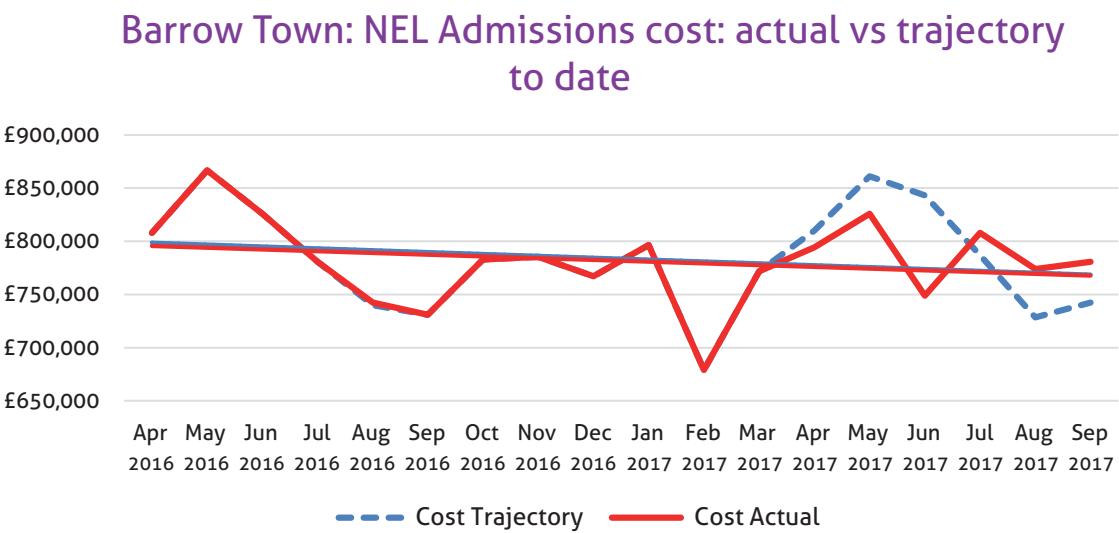
► Figure 37 Non-Elective Admissions cost: BCT-wide

BCT: NEL Admissions cost: actual vs. trajectory since vanguard funding

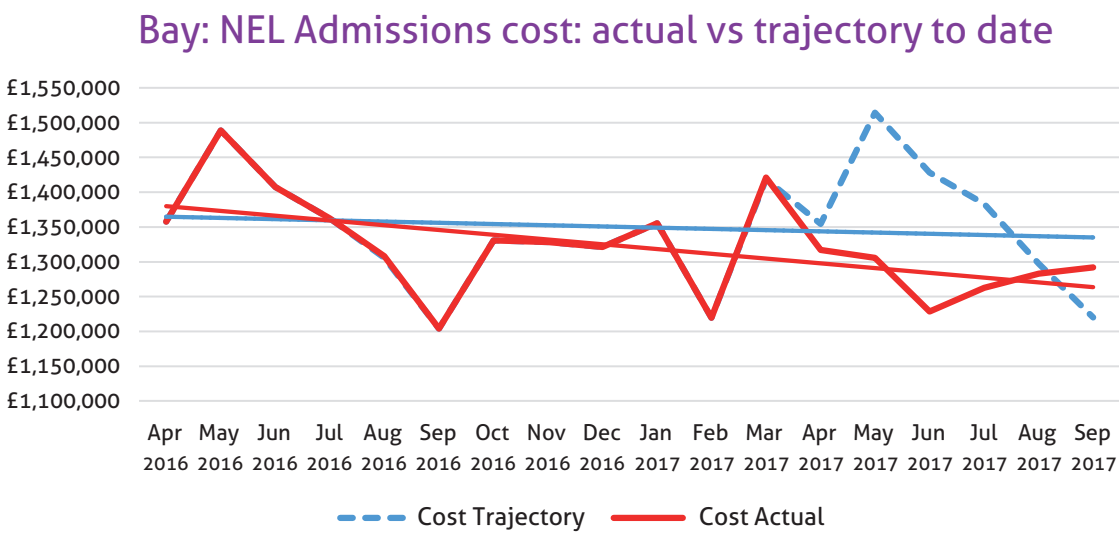


► Figure 38 Non-Elective Admissions cost since vanguard: BCT-wide

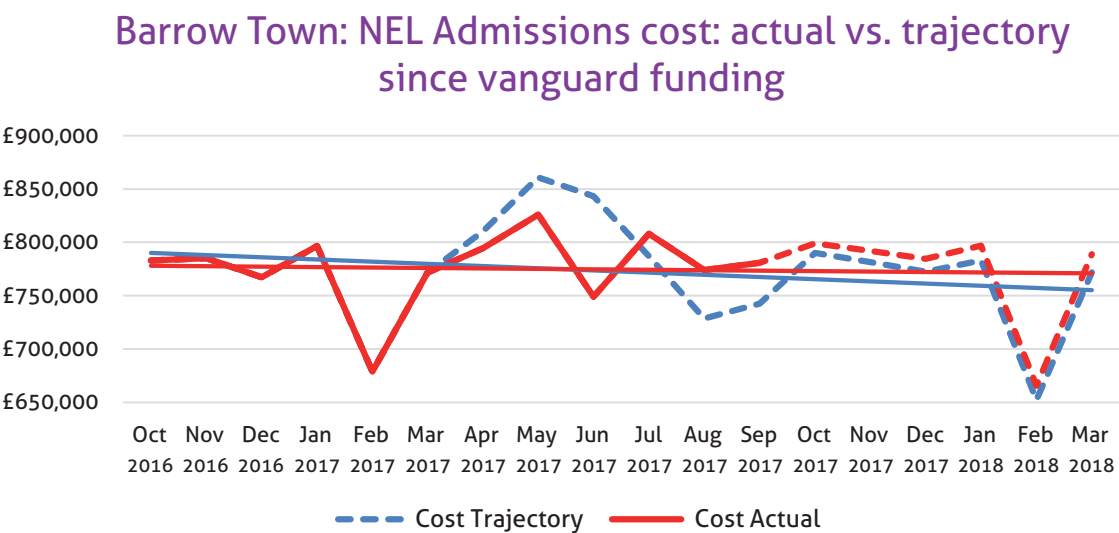
³³ Department of Health. NHS reference costs 2015-2016.



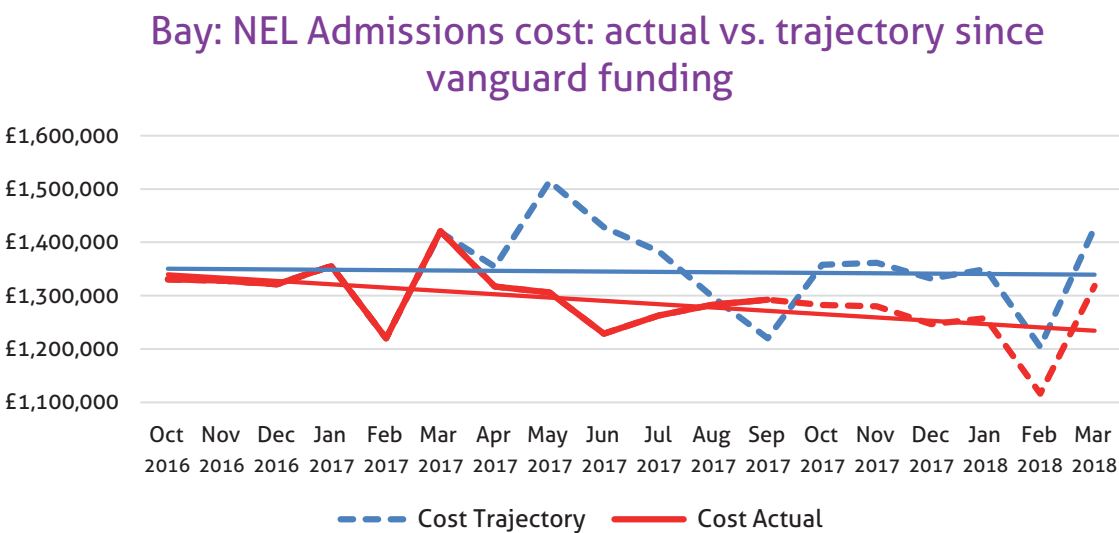
► Figure 39 Non-Elective Admissions cost: Barrow Town



► Figure 41 Non-Elective Admissions cost: Bay

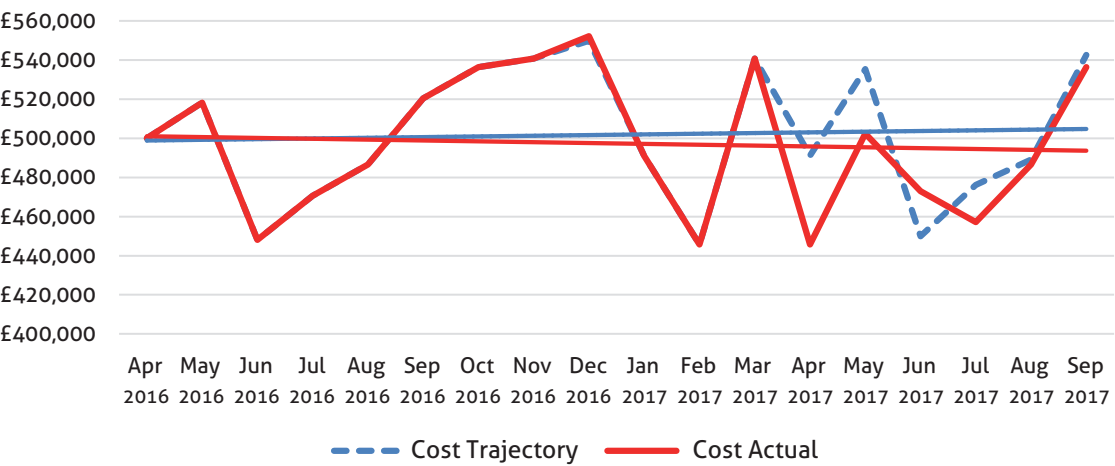


► Figure 40 Non-Elective Admissions cost since vanguard: Barrow Town



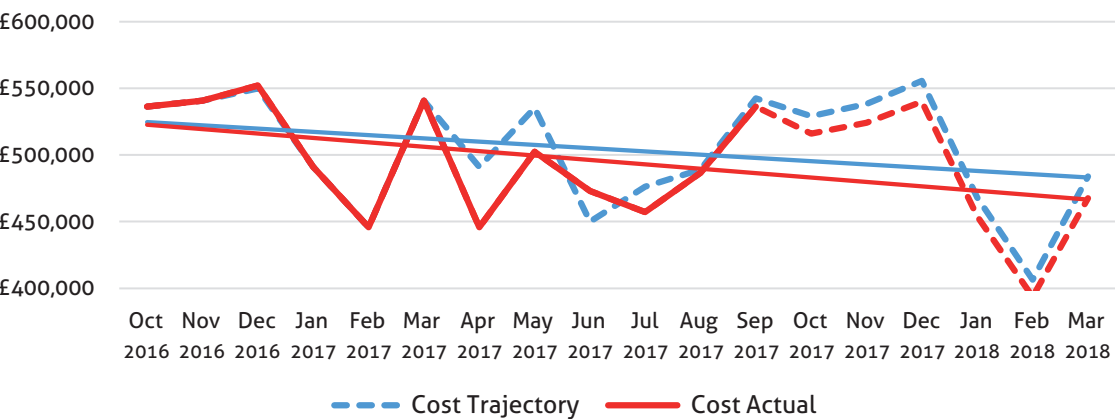
► Figure 42 Non-Elective Admissions cost since vanguard: Bay

East: NEL Admissions cost: actual vs trajectory to date



► Figure 43 Non-Elective Admissions cost: East

East: NEL Admissions cost: actual vs. trajectory since vanguard funding



► Figure 44 Non-Elective Admissions cost since vanguard: East

Non-Elective Bed days

Non-elective bed days relate to the length of stay of patients who have been admitted to hospital through emergency (non-elective) services. While the majority of admissions to hospital are elective patients (61% in the BCT area in 2016/17), they occupy only about 10% of bed days. In turn, 90% of bed days are occupied by non-elective patients, which means that reducing bed use for emergency admissions offers greater potential to deliver an overall reduction in the use of hospital beds and associated cost savings. The average bed day cost has been calculated as £283, on the basis of the average cost of excess bed days in the National Schedule of Reference Cost 2015-2016³⁴ and adjusted for the Morecambe Bay market forces factor.

BCT	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£54,993,976		
Oct 16 – Sept 17	£51,531,947	£53,637,566	–£2,105,618
Difference year/year	–£3,462,029		

► Table 22 Non-Elective Bed days cost: BCT-wide

Barrow Town	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£6,980,581		
Oct 16 – Sept 17	£6,728,771	£7,087,720	–£358,948
Difference year/year	–£251,810		

► Table 23 Non-Elective Bed days cost: Barrow Town

Bay	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£9,340,695		
Oct 16 – Sept 17	£9,539,091	£9,161,657	£377,434
Difference year/year	£198,395		

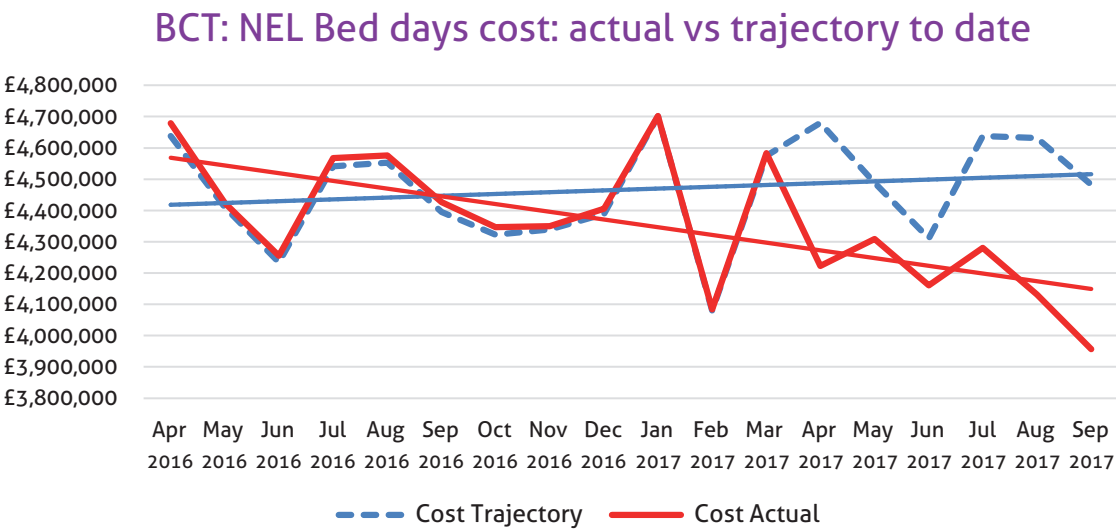
► Table 24 Non-Elective Bed days cost: Bay

East	Cost actual	Cost trajectory	Difference actual/trajectory
Oct 15 – Sept 16	£4,814,340		
Oct 16 – Sept 17	£4,376,005	£4,771,444	–£395,440
Difference year/year	–£438,335	£4,771,444	

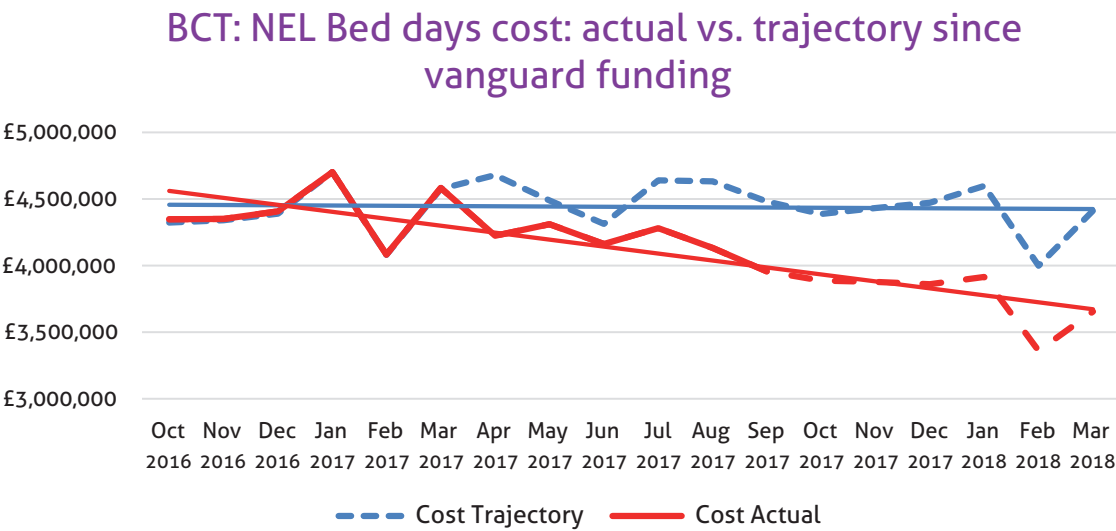
► Table 25 Non-Elective Bed days cost: East

34 Department of Health. NHS reference costs 2015-2016.

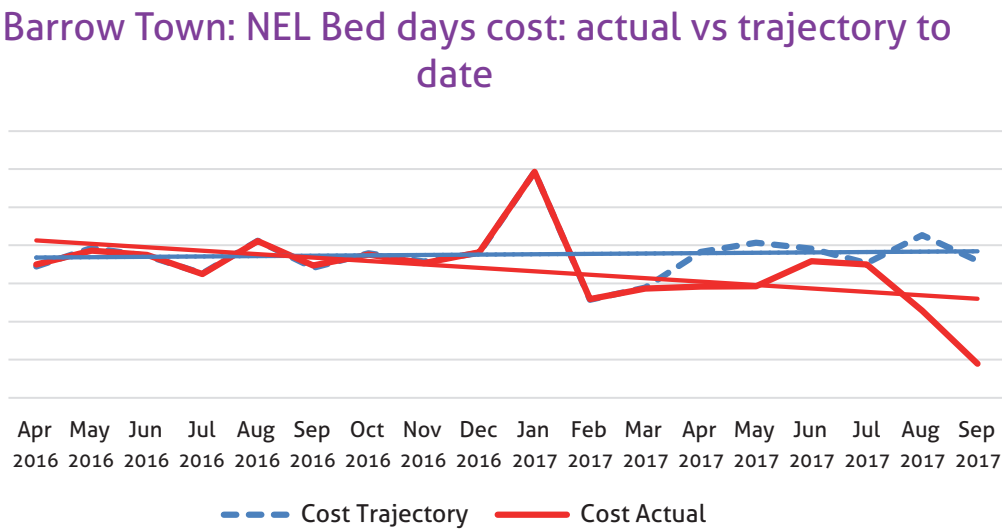
As can be seen from the tables above, there was a reduction in cost of non-elective bed days by just under £3.5m last year as compared to the year before and also registers a saving compared to the 'do nothing' trajectory. Barrow Town and East also indicate reduced costs, both in the year on year comparison and against the trajectory. In Bay ICC, on the other hand, costs for non-elective admissions rose last year compared to the previous year, as did actual costs against the trajectory. This trend is also markedly visible in the comparative graphs below:



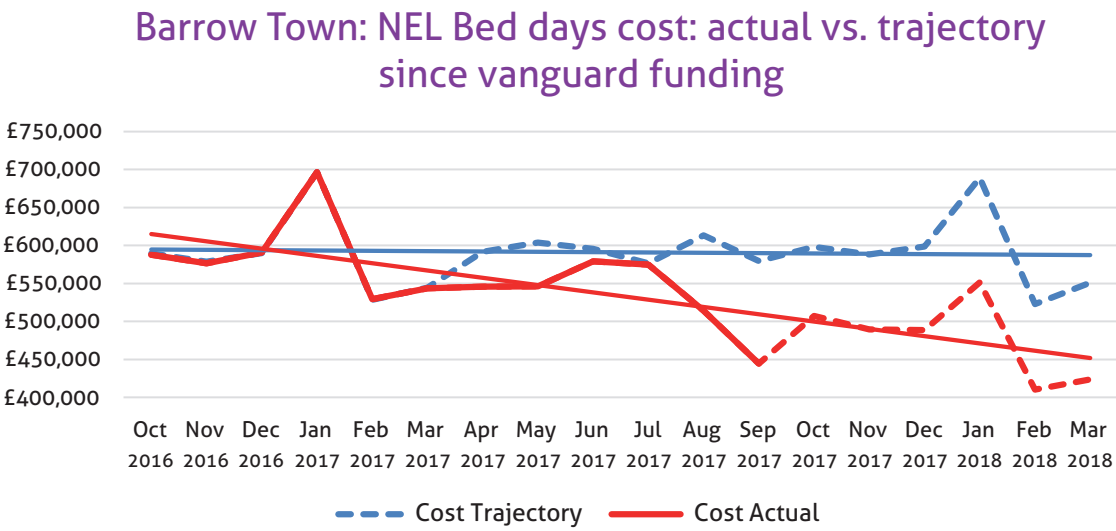
► Figure 45 Non-Elective Bed days cost: BCT



► Figure 46 Non-Elective Bed days cost since vanguard: BCT

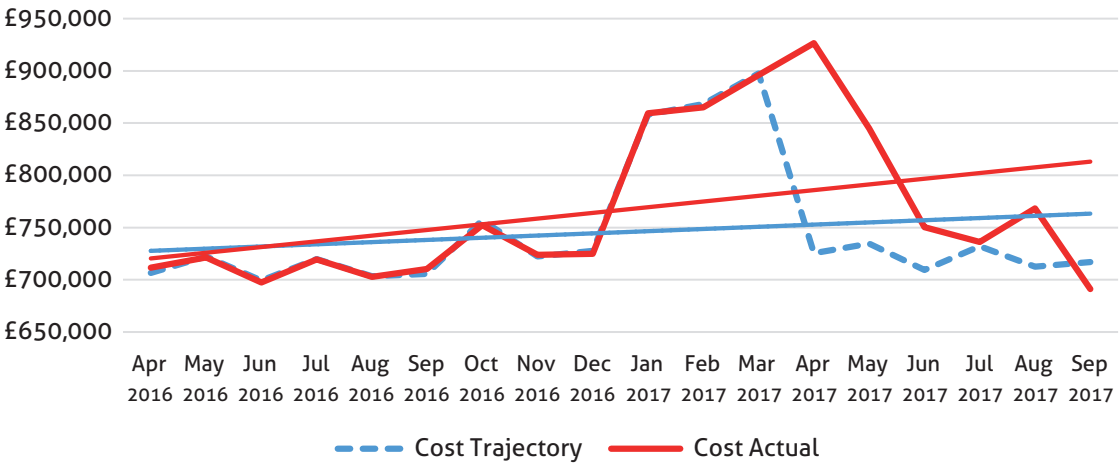


► Figure 47 Non-Elective Bed days cost: Barrow Town



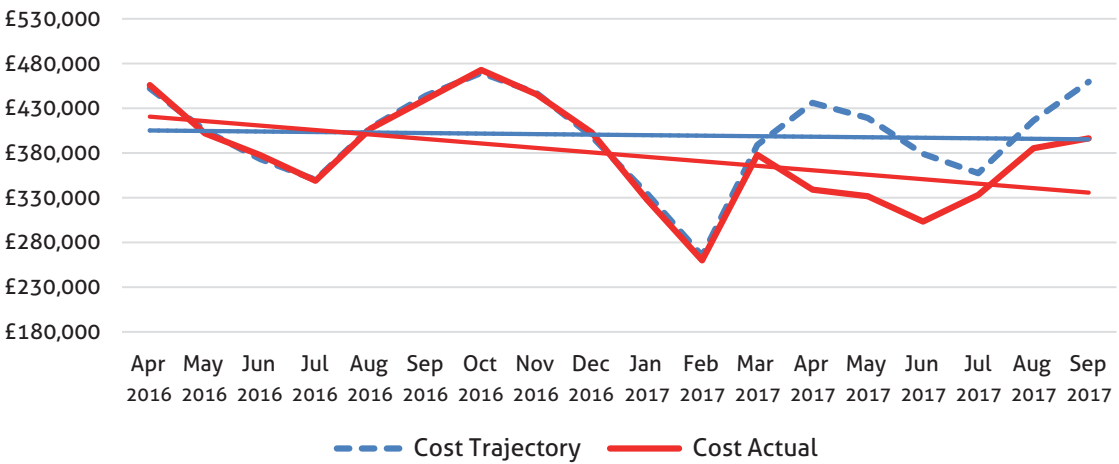
► Figure 48 Non-Elective Bed days cost since vanguard: Barrow Town

Bay: NEL Bed days cost: actual vs trajectory to date



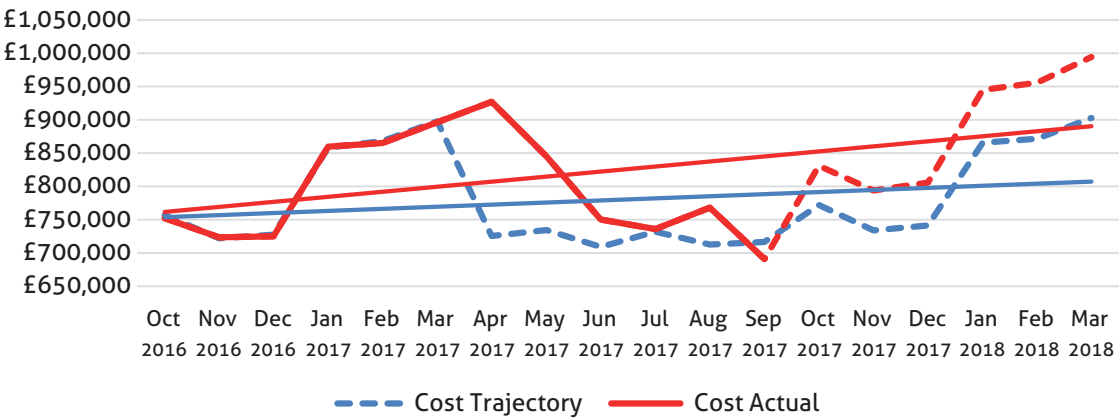
► Figure 49 Non-Elective Bed days cost: Bay

East: NEL Bed days cost: actual vs trajectory to date



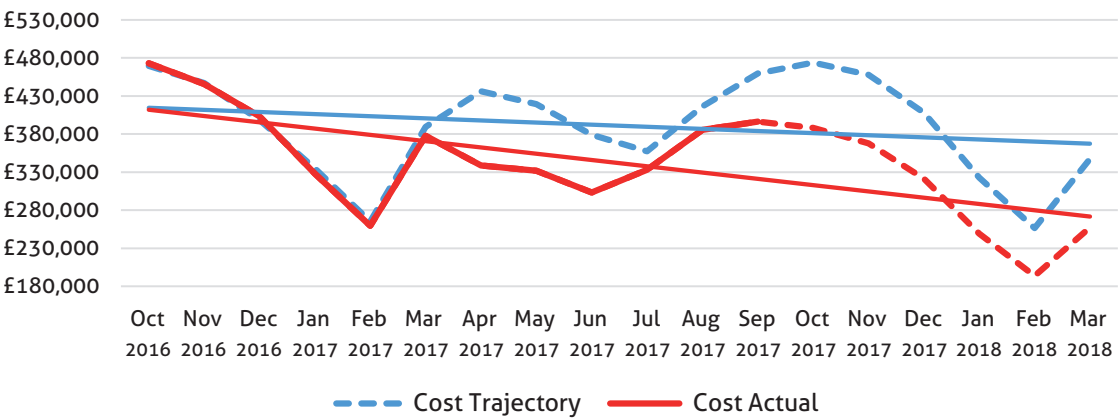
► Figure 51 Non-Elective Bed days cost: East

Bay: NEL Bed days cost: actual vs. trajectory since vanguard funding



► Figure 50 Non-Elective Bed days cost since vanguard: Bay

East: NEL Bed days cost: actual vs. trajectory since vanguard funding



► Figure 52 Non-Elective Bed days cost since vanguard: East

Bed Reduction

According to a recent report from The King’s Fund in England, the number of general and acute beds has fallen by 43 per cent since 1987/8, with the bulk of this fall being due to the closures of beds for the long-term care of older people. Medical innovation, including an increase in day-case surgery, has also had an impact by reducing the time that many patients spend in hospital.

While the rate of decrease in bed numbers has slowed in recent years, there are opportunities to make better use of existing bed stock by preventing avoidable admissions, reducing variations in length of stay and improving the discharge of patients.³⁵ The effects of these efforts to make better use of existing bed stock are shown through the non-elective bed day metric above. The King’s Fund report continues:

*Today there are signs of a growing shortage of beds. In 2016/17, overnight general and acute bed occupancy averaged 90.3 per cent, and regularly exceeded 95 per cent in winter, well above the level many consider safe. In this context, proposals put forward in some sustainability and transformation plans to deliver significant reductions in the number of beds are unrealistic.*³⁶

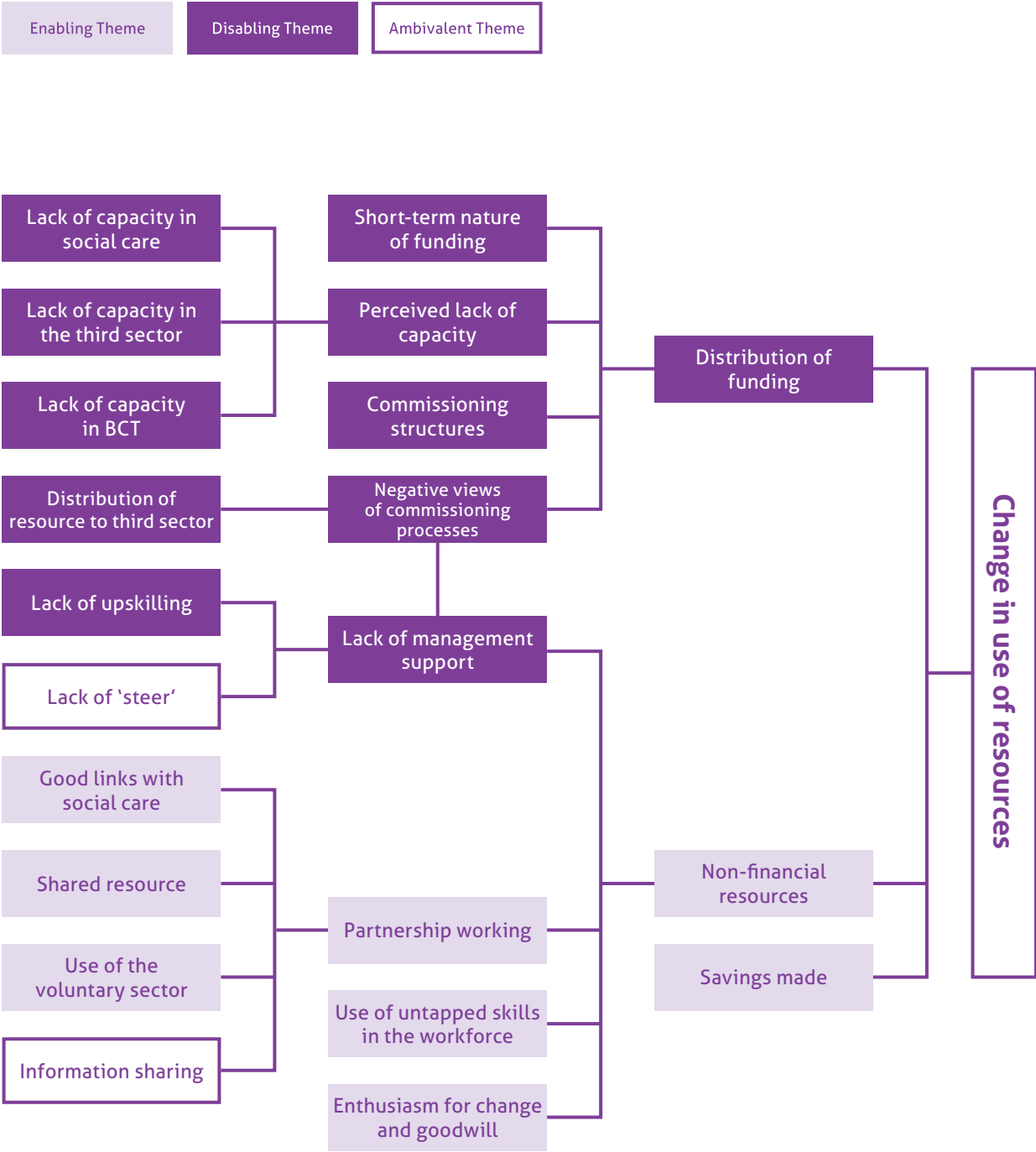
For the BCT area, overnight general and acute bed occupancy averaged 85% since vanguard onset in October 2016, with a peak of 87.8% in March 2017. Compared to this, the average bed occupancy in the same time period the year before was 86%, with a peak of 89.2% in January 2016. This slight reduction in occupancy is achieved despite a reduction in available beds. Between October 2016 and July 2017, the average number of available beds dropped by 23, from 676 to 653, reducing available bed days from 20949 to 20232. With the average bed day cost calculated at £337 (taking into account the distribution of elective and non-elective patients at 10% to 90%, as discussed in the previous section), this suggests an overall saving through bed reduction of £241,291 for the BCT area.

7.3 Qualitative Analysis of Changes in Resource Use

7.3.1 Thematic Overview

As with all areas of qualitative analysis, interview data regarding resource use was organised thematically in order to identify patterns, regularities and significances in participant responses. A diagram of themes is presented below, followed by a narrative of the qualitative findings around resource use.

35 The King’s Fund. NHS hospital bed numbers: past, present and future. (2017) <https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers>
36 The King’s Fund. NHS hospital bed numbers.



► Figure 53 Change in Use of Resources - Thematic Diagram

7.3.2 Distribution of Funding

While all participants were asked to discuss the changes in resources they had seen, few identified tangible changes. Instead, the data analysis shows the issue of resources raised a number of deep concerns around the meaning of resource use to practitioners, including:

- the distribution of funding and the decision-making behind it;
- different funding models for primary and acute care;
- how resource was translated into delivery, and the effect of funding structures on delivery and morale.

One of the major discussion points around resources was the distribution of the vanguard money, and of the BCT investments more generally. As the Figure 53 shows, all of the themes emerging under this heading were negative or reporting disabling mechanisms for change.

A recurrent theme around funding related to its short-term nature, and the problems this raised for delivering sustainable change. According to many participants, the programme has been driven by short-term and non-recurrent funding with little or no preceding investment in affected services. This has been reported to contribute to disengagement of the workforce and generate outcomes that are vulnerable to reversal change, following conclusion of the programme.

One of the bones of contention being the fact that we've been an ongoing stop-start because of funding. Even now we don't know what's going on with it. (INT047)

We've had several Project Managers, and that lack of continuity has not helped at all... it's a long-term project, it's a long-term aim, but the money is all short-term. So, we've only just found out that next year's monies are there. And also that doesn't help with the work force, or with planning, or with what we might hope to achieve. (INT050)

This was mentioned across a range of interventions, including MSK:

The funding comes from vanguard for another six months. What happens after that, nobody knows. That uncertainty is certainly having an effect on the recruitment of staff into the service. We're sort of in a pilot phase, but nobody really knows what's going to happen. (INT029)

In this context, an unintended consequence of vanguard funding was to introduce more, rather than less, uncertainty into areas of practice:

But then, we get told that apparently at the end of February, the funding for the Telehealth is finishing...because it was only a pilot. And then it's like, "Oh, well it doesn't matter, there'll be funding from somewhere else." But it just creates uncertainty and then everybody is like, "Why are we bothering now with the Telehealth, if we're not going to be able to carry on with it?" (INT052)

However, the importance of being able to trial new ways of working did provide a model for longer-term investment, and with it a belief that if the funding could be extended there would be further opportunities to backfill the current volunteers' posts and extend the service. This was seen in the MSK work:

Once we get permanent funding we'll be able to potentially recruit to the new session and backfill the old ones. So, that's part of the problem with doing things on a trial or test basis without permanent funding. We've not been able to recruit to the backfill. (INT039)

The delivery of the NCM sits not only within a complicated history of service improvement interventions in Morecambe Bay, but also alongside multiple and competing demands associated with both pre-existing BCT initiatives and wider NHS strategies. This was sometimes seen as a disabling context:

To some extent, the vanguard award which came was a bit of a hindrance. Because we were trying to deliver the BCT strategy ... [and] trying to serve the Five Year Forward View vanguard team expectations. In terms of resource, it was a limited resource we had from vanguard and there was competition between work streams for that scarce resource, which has been shrinking. And I think as the vanguard award shrunk, our ability to move things forward became inhibited. (INT009)

About three years or so ago... we were trying to put some stuff together for the CCG, to try and develop MSK care. That all came to a halt because then we were told, "No, you can't do any more, it's only going to be part of BCT and vanguard." (INT029)

One of the added problems of vanguard-specific resource was the perception that support for initiatives is tied to the project management structure of BCT. For example, it was noted in the previous chapter that at ICC level, many care coordinators had raised the 'lack of steer' from managers as something which could be potentially beneficial, but was also problematic in terms of the support available. In one North Lancs ICC, the care coordinator feels that while the GPs are on-board, middle-management could prevent the role holder implementing new ways of working and rolling out new ideas. Here, the measure of support is linked to the commissioning process:

It's middle management where I'm getting the blockers put on me... I'm presuming it's because I've not been commissioned, or they've not been commissioned to provide this service. I don't really know... but I'm being left to get on with it now because they're seeing positive results. (INT059)

In this sense, the 'lack of steer' can be interpreted positively (projects left to develop while they show positive results), as well as negatively (if more support is needed). In other areas, the lack of a leadership steer could lead to competing demands of several different managers:

There's an issue as well because we work for several GP surgeries. Some want some things and some want others, so it can be hard to determine that, let alone put it in place sometimes. So it's just getting some consistency... even some of the paperwork we do, some of the surgeries want certain things doing... and then others aren't so keen on it, so we don't really know whether we're doing it or not at times. There's been an issue with not having a Case Manager and not having a very definite Senior Manager to coordinate that, is part of the issue. (INT044)

There were similar concerns raised around the capacity outside of BCT. As a clearly stated aim of BCT is to keep frail and elderly people out of hospital, social care forms a vital role in this. However, participants – particularly in South Cumbria – reported problems with capacity and funding in both statutory and third sector organisations. A number of participants noted that this was a key preventer in the successful delivery of the BCT strategy. All of the following quotes are from South Cumbria ICCs:

We're supposed to be a fairly short-term service, and bringing in other services to support. Sometimes the third sector isn't there and even with either the NHS or the Social Services, it's an issue of capacity a lot of the time... then that obviously keeps them on our caseload and possibly increases the risk that they will go into hospital in between, whilst they are waiting for services. (INT044)

Being in post in the first three months, we'd already saturated the third sector, the Age UK and Sight Advice because we'd blocked their referral services up. (INT049)

I've just been told recently to utilise Age UK's befriending service and... apparently, the money has run out for that now, so the best they can do is maybe offer a telephone befriending service, but again that's not even guaranteed. (INT060)

Well the clear directive is to try and reduce admissions...but I think that directive is slightly unattainable, because of the severe lack of Social Care... I think there are not the carers on the ground where we are, because we're in a rural area. (INT047)

They've got major issues with staff sickness, and just not enough Social Workers anyway, but obviously we need a lot more input and I don't think we're going to get it anytime soon. (INT044)

I think the biggest strain on resources is Adult Social Care... we don't even know who our Social Worker is. (INT047)

This was also linked to the problem of general staff recruitment and attrition issues reported in the South Cumbria area (see Chapter 8):

In the area where I work, there's not enough home care. People have been stuck in the hospital because they can't get home, because there's no care agencies and there's not enough care for the area. (INT048)

Conversely, where links between social care and the ICC were stronger, participants were more confident of producing successful outcomes.

...because we can never get Social Workers, one of the Social Care Workers showed her [an Assistant Practitioner] how to do re-ablement plans... She's the most informed person to write these plans. So she passes them up to Social Work so we can work more collaboratively... to get people discharged. It's an informal agreement, but as long as somebody does it. It's okayed by Social Care. It works really, really well. (INT051)

...we have really good links now with Social Services...we've got a Social Worker linked in to our ICC, so now if we have any social aspects that we need to clarify, it's just a case of picking up the phone or emailing...likewise, with the voluntary sector as well, we've built up really good links with Age UK. (INT060)

The number of demands on more senior staff in the public and voluntary sectors and how this impacted their ability to engage was also an issue:

I tend to get invited to quite a few things, or I might get invited to have a seat at a certain meeting, but because there's generally only me that's got a portfolio for health and well-being, at a senior level, my problem is that I just don't have the capacity to service everything. So, I have got a seat on the OOH implementation meeting, which is great. I've been to the occasional meeting, but they are about every month, and I just can't make them all. (INT027)

Alongside concerns around the capacity of Social Care and the Third Sector, there were also negative views expressed about the distribution of resource around BCT itself. There was a recognition that the time required for system change to be designed and take place placed a large demand on clinical staff. This can not only affect the delivery of changes, but also the way in which decisions are made at more strategic levels, as clinicians may be prevented from engaging in the conversations which, as reported in Chapter 6, have so far been crucial enabling mechanisms for the NCM:

And the Clinicians we have are doing day-to-day service delivery. They don't have protected sessions for other things, if you like. They've got patients to see. So, although I try and involve my Clinicians in the pathway development, because they're the experts... you can't get them around tables at Senior meetings. (INT043)

But much of the concerns around capacity came back to funding:

There is no resource ... I'm funded one day per week, how do you expect somebody to transform a whole health system in a day per week for six months. (INT054)

INTERVIEWER: ... Has there been any upskilling or role redesign involved? INTERVIEWEE: No, we've had no changes. There's been no support from management. (INT045)

In this context, the following observation from one South Cumbria ICC is key, as it raises the issue around the extent to which a return on investment, and general effectiveness of a programme, will vary depending upon existing assets and skills within a team or area.

We were just left to make the service -- within the [ICC], we moulded it into the way that we thought would work better... it's been hit and miss, but because of the skills that we have in the team... we've got some background in all areas... The GPs seemed happy with the way that there's actually more of a service for our patients. (INT045)

One of the problems associated with the localised responses which form the basis of many of the successes in BCT was the way in which resource use could be tracked from input to outcome. It was noted in the overview (Section 7.1) that identifying inputs into the resource chain was problematic. In part, this was attributed to separate commissioning structures at work within the programme:

The acute Trust are on a tariff, [while] we're on block. So, what happens is we get more and more work thrown at us for no additional money, no additional resource. So, if my District Nurses had 100 visits in one day, they're going to end up with 130, but no more Nurses to do it. So all of that doesn't lend itself to ensuring that we embed or change services. (INT043)

BCT is a means of creating change, but change is very slow; "it feels like we are being sucked into the giant machine that is the healthcare system... as soon as you try to change something, you're changing contracts, which are quite complicated." (INT064)

The task of bringing together ten different organisations as 'Bay Health and Care Partners' has also proved problematic at an operational level:

BCT is obviously about a system-wide approach, but our individual organisations don't allow us to deliver BCT. So, the barriers if anything are the organisational constraints... NHS England have come and said, here's some money, with your vanguard status, deliver BCT... But what they haven't done is set the permissions level to say, on this occasion, don't worry about IT between organisations... (INT061)

Likewise, the cohesion of the system-wide approach was challenged by competing programmes of work and performance indicators:

Our commissioning arrangements don't support it [change], because I'm still held to deliver on previous KPIs. So, if we can't double run, the only way we can do it is to move our deck chairs. But if I'm held to deliver on previous KPIs, I can't move my deck chairs in the way that I need to, to enable that change to happen. (INT043)

Participants' views that distribution of funding was problematic due to its temporariness was also linked to the decision-making structures and involvement of other care deliverers. This was perceived to interfere with some of the localised solutions which were being developed as part of ICC development, for example:

We're being told as ICCs, "You need to have free rein to identify -- because you know your population, you need to do what's right."...But when it comes to actually any decision making - any transparency over how much money is available, what it can be spent on, we don't get given that...And often, the decisions that are made higher up are completely disjointed from what's happening in the ICC. (INT054)

This view of a disconnection between decision-makers and the lived contexts of the region was raised in a broader sense by a participant from the voluntary sector:

The BCT strategy does really need to think about its wider partnership and what assets they can bring to making this a successful implantation. So, I think there is still mileage in making sure that they involve people and the right people. And I think there has to be a cleverer way of distributing funding as well. You know, we bring so much to it, but we virtually get nothing from it. (INT028)

There were more positive notes, however, around improvements in the distribution of resources related to the growing evidence around the shift to a wider understanding of wellbeing (see Chapter 6):

I think there's an increased and improved understanding of why things like lunch clubs have had a value. Because lunch clubs just sounds like, well, why would anybody pay for that, why would anybody commission that? And the answer is, actually, for lots of reasons. And not about the food. (INT058)

The work in the Ophthalmology pathway, whereby certain conditions were contracted out to the private sector, was raised as a good example of managing relationships and communication between organisations:

The model across in Morecambe Bay allows the Trust to sub-contract out to the Optical Practices, so the Optical Practices and the staff within them become the face of the Trust. ... In other models, you've got a situation where the commissioners will potentially decommission from one organisation, to recommission with another. It immediately puts the provider organisations at odds, if you like. Almost thinking as businesses rather than clinical providers. The model across Morecambe Bay is really a good example of how clinicians coming together can support a better service around patients. (INT042)

7.3.3 Non-financial Resources

In contrast to the themes around the distribution of funding, far more positive themes could be identified from the data collected around the idea that resources other than money were important and could be valued more when they are shared. The negative themes drawn from the analysis focus on management support, and the tension between the freedom to develop new ideas at local levels, and a perceived lack of steer or support from middle management upwards.

The role of partnership working in utilising resources in a more efficient way was noted by a number of participants, particularly those from the voluntary sector. At the time of data collection, this was still felt to be in a nascent stage, but the possibilities that some of the BCT initiatives were offering was promising:

I think in the voluntary sector, and I think at community level, there's a lot of resources that can be better utilised. So, there's buildings, a lot of buildings that could be better utilised. And we are giving that. We are allowing people to share resources, share buildings, you know, share meeting spaces or main halls and so on, for nothing. And we give that for nothing, so it's -- so we are giving stuff. (INT028)

In some interventions, such as the MSK pathway, the intention was to utilise community resources, so that patients could be seen closer to home than the general hospital. However, practical issues and availability had led to what one participant described as a 'hybrid', whereby some clinics had been run in a health facility in Dalton, and others in Westmoreland General Hospital:

We didn't intend to run [the clinics] on a hospital site but that's working well initially. Plan A was to use community facilities, and we're still working on that as a next phase. We're looking to introduce another five clinics in the next financial year, and we're working on a couple of options. So yes, that's a bit of a hybrid from the intended direction, it's not quite turned out as we expected, really. (INT039)

It is important to note, though, that the 'stuff' referred to, though, is not just physical things, but knowledge, connections and relationships.

I think people work with people and people that work in these very difficult communities, they know people, they know families, they know the hot spots, they know young people, they know local businesses. I mean they're devalued in that really. They bring a lot of wealth and resources in that sense. (INT028)

Also there was a desire to identify and share further resources towards their joint objectives, which built upon the work around identifying gaps in local health provision.

We have used third sector a lot, and a lot of the time that is -- not in place of Social Services, they still need that assessment -- but sometimes it's to sort of put something in in the meantime to make things a little bit easier. (INT044)

I think it is about training and that awareness raising. We work [with], or we come across... ICC Practitioners, and these are Nurses that are working on the front-line in communities. And they quite often say, you know, "We're a bit frustrated about what's available in our community, and we're frustrated about the referral pathway." So, for example if they come across someone who needs to go on a food-related programme, on a diet programme or fitness programme, you know, they want to know what's available and how to make that referral. So, there's a big need for them to have some kind of database, accessible database that they could -- even an app, maybe or something? You know, using technology far better than we are. (INT028)

At the same time, there was recognition that more work on IG and technology was needed.

For me, the barriers have been the information governance, the technology systems that have got absolutely no way of speaking to each other. You pull off system data on the same patient population, you'll definitely get two different answers. (INT061)

One of the consequences of the programme delivery is the identification of specific gaps around IT and IG which have historically contributed to the architectural obstacles to integrated care. While this is a prominent problem reported by vanguard sites nationally, there are a number of localised solutions which participants have reported, including contracting staff on 'honorary' contracts at General Practices to assist with data access. In general, though, these were operational at local levels, rather than system-wide initiatives; and procedures for sharing data tended to vary according to the existing relationships between organisations. While there has been some progress in integrating IT and IG structures in the later half of 2017, these had not filtered through to the operational level of delivery at the point of data collection.

The 2017/18 evaluation will explore some of the more recent developments around technology, particularly in relation to the Frailty pathway and its links with the Third Sector.

A number of participants noted the relationship between successful pilots and interventions and the use of existing assets within a community.

We were asking for an additional clinic a week, on top of local physio work plans. ... The level of experience and knowledge and qualification was exceptional. Two of the 14 have got PhDs in physiotherapy. Several were MSc. It was quite surprising in a way. I don't think we'd realised the extent of the potential locally, which is untapped. That was from the three local providers, Cumbria Partnership, Lancashire North and Morecambe Bay Hospitals. So, that was really quite pleasing, that there's a huge range of people who have obviously invested a lot of their own time in developing skills which weren't being utilised. (INT039)

I think what specifically also helped Ophthalmology is that with Optometrists, we already had a big cohort of community providers as our capacity available, which probably made it a bit easier for Ophthalmology than it will be for some of the other specialties, because they will be relying a lot more on already overstretched workforce in their area. (INT030)

There was seen to be a positive use of higher-level skills that Optometrists had been trained in but hadn't been using in their practices making their work more interesting and therefore them more likely to engage.

Out in the Optical practise, Optometrists have their core contract, which allows them to do sight testing and provide services. Beyond that they have to refer in. So, if they identify an abnormality, they refer on to another level of care. Actually, that's very frustrating for Optometrists, because they've got the skillset and they've got the equipment to do much, much more, but they haven't got the contract in place to deliver that. What we're allowing community Optometrists to do is to work within their core competencies, but do more for their patients. Once they've identified there's a problem, there is a lot more they can do to manage their own patients and do it very promptly. So, there's a lot of job satisfaction comes from that. (INTO42)

I think it's positive for the profession too, because Optometrists are trained to do lots of things that they don't get to do very often, because the NHS won't pay them for it, and customers aren't used to paying for it. So, it fills in a nice gap. (INTO35)

The following quote illustrates how one participant links the issue of resource through some key ICC themes: upskilling, communication, care plans and the ultimate aim of keeping people out of hospital.

...it's more down to communication and informing them of pathways and ways of more clinical working. If they've got a Care Plan, they need to be following it. It's that kind of upskilling in the fact that, "Look, you need to know about these things that are coming out and you need to be using them and these pathways to keep people at home." And that's our agenda, to try and treat people more in the community than them going to hospital... It's just highlighting that we need to think about changing the way we work and communicating better. (INTO53)

This was characterised by the educational opportunities that multi-disciplinary teams provided:

There's been a kind of shared, education...[with] the consultant understanding better what the primary care is able to do. But also, primary care picking up education from the consultant's viewpoint as well. (INTO01)

The positives have definitely been ...the fact that we have upskilled ourselves... with mobility aids and equipment, which is something that we would never normally have got involved in...to a degree it prevents hospital admission, because sometimes it can be a vital piece of equipment because somebody has fallen when they get out of bed first thing in the morning. It could be something as simple as a bed lever, to hold on to. (INTO55)

The process of shared education is associated with a wider culture change where the professionals are required to bridge the traditional divides in knowledge and approach between clinicians working in community settings, and those in acute settings. In the case of the Advice and Guidance project, for example:

There's a kind of growing realisation by the consultants that actually GPs are approachable and...they can learn a lot from each other and...similarly with primary care. Over time... barriers have built up between secondary and primary care, it feels that those barriers are now starting to come down. (INTO01).

I think the more we bring people together, the more they learn about each other's role and each other's expertise, the more confidence they have in each other...that the other has a good understanding of the necessary clinical provision that is required for their patients. (INTO13)

One of the advantages, where you start to have two teams working close together is, the next step is to say, "Well actually, let's have a bit of rotation in that team." And that means that if one person in one team is ill...then you've got a bigger group of people that you can use to cover that gap. (INTO22)

In this way, mechanisms which enabled shared understanding of individual roles and competencies between primary and secondary care (such as the introduction of the Professional Pathways in Primary Care for paediatric assessment) increase confidence in service provision in alternative settings, and engage with the view, consistent across North Lancashire and South Cumbria, that historical divides between these areas are major barriers to wider system integration. Capturing the outcomes of these interventions in a meaningful way, however, is not straightforward.

Finally, one of the main resources to figure as an enabler for change was the goodwill of those involved. It became apparent both from interviews and PDSA reports that a large amount of work in BCT projects was being undertaken based on goodwill and extra hours put in by staff. There was a distinct theme within the data that suggested while this was a key enabling mechanism, it was also a finite resource.

The main thing is the lack of -- my time is funded, but when the surgeries, or the ICC member Practices, none of their time is funded... it has to be an evening meeting, so it's, a lot of it is done on goodwill from member Practices... they have no funded time to think outside the box and to plan and therefore it's all done on goodwill. (INTO50)

When people have already been working well beyond their employed time and giving discretionary effort, and trying to flag up that there's a problem for decades. It becomes very difficult for them to believe that the cavalry has actually arrived, that this is actually a solution...Because you've made do and mended for so long, that if there suddenly is a resource, then people are suspicious of it. (INTO24)

On this note, some participants noted the diverse knock-on effects of limited resources; in the example they gave, isolated patients who aren't on a bus route may miss appointments and become unduly frail, which is coupled with the wearing-down of goodwill among staff who get involved in a service only to see it end can lead to low morale and cynicism.

One of the key things is transport... if someone has a medical condition... their driving license is revoked...It can have a massive impact...The other side of it, is the fact that the service is there and then six - twelve months later it's not there anymore. And you've really pushed it and got people involved with it and it's just disappeared really. It's all down to money, isn't it? (INTO60)

7.4 Discussion and Summary

The aim of this section of the evaluation was to identify changes in resource use and cost for the specific interventions and evaluating the vanguard's performance against its expectations.

- The main challenge in answering these questions for this evaluation has been that much of the new care model is very much in the developing stages, and the above questions make extensive assumptions about the availability of data that does not yet exist in an evaluable form. Therefore, as the design of interventions was still in progress, we could not finalise evaluation methods at this stage of the NCM's delivery.
- Because the interventions being put in place target relatively small populations, identifying the appropriate data for capturing progress remains a major challenge. A preferable dataset would be at patient level, linked across all care sectors. It has proved extremely difficult, however, to obtain data on this level.
- Without this data, we have used intermediate data of overall hospital and outpatient activity to evaluate the potential financial impact on the healthcare system. While these are a good indicator of overall performance of BCT as a whole and individual ICCs, the link between individual interventions and these metrics is tenuous and, as the target populations of the interventions are small, their effects might not be noticeable on the larger scale metrics.

8 Outcomes

Furthermore, it is clear that the figures presented within this economic analysis represent resource use and associated cost only, in other words, outputs. Due to data availability issues, however, we were not able to include cost inputs in the economic analysis, which would have to be applied on a much lower level of individual interventions and include data about changes in staffing structures, processes and the associated cost implications.

- As the qualitative data has shown, there are further non-financial inputs which amount to a resource cost: for example, the amount of extra hours put in by staff to deliver pilot interventions, and the dependency on 'enthusiasm and goodwill' which needs to be represented in order to accurately identify the full resource impact of the NCM.
- In some cases, a measure for this might be as basic as 'time'. A straight forward way of beginning such a measure of the time taken to implement delivery would be to collate meeting minutes and take from these numbers/roles of attendees, hours taken, and positive outcomes which can be measured and tracked against project timelines (to demonstrate any differences between time resources needed at the earlier and alter stages of the activity).

Moving forward into the next phase of the evaluation, the following points could address the disparity between the requirements of the economic evaluation and the currentavailability of comparable data:

- Specific data needs to be obtained for individual interventions on patient level.
- Input as well as output data should cover enough breadth to measure the impact of the intervention on a patient level.
- Where linked patient data is not available, secondary care episodes might be picked up in primary care systems, if such data is entered and correctly coded.
- Where secondary care data is aggregated, attempts should be made to fit the aggregated data to the target population as closely as possible.
- Furthermore, appropriate baselines for input and output data have to be identified on intervention level. Ideally, this baseline data will take account ofgeneral underlying trends, in order to enable meaningful before and aftercomparisons.

The qualitative data raised an important question regarding the extent to which a return on investment, and the general effectiveness of a programme, will vary depending upon existing assets and skills within a team or area. Because interventions are currently working in very localised ways, this data is not being examined consistently. Someparticipants cite existing or untapped skills as vital to the success of an intervention.

- The programme deliverers may want to consider mapping existing community assets, BCT investment and social care figures in order to follow through theimpact of their outputs and outcomes on the health economy as a whole.

The generally negative views over the distribution of funding link to several aspects around the NCM. Certain themes, such as around the commissioning structures themselves, are embedded differences between primary and acute care. Others, however, centre on the transparency of decision-making around funding, the communication of capacity issues to management and the tension between the freedomto develop new ideas at local levels, and a perceived lack of steer or support from middle management upwards.

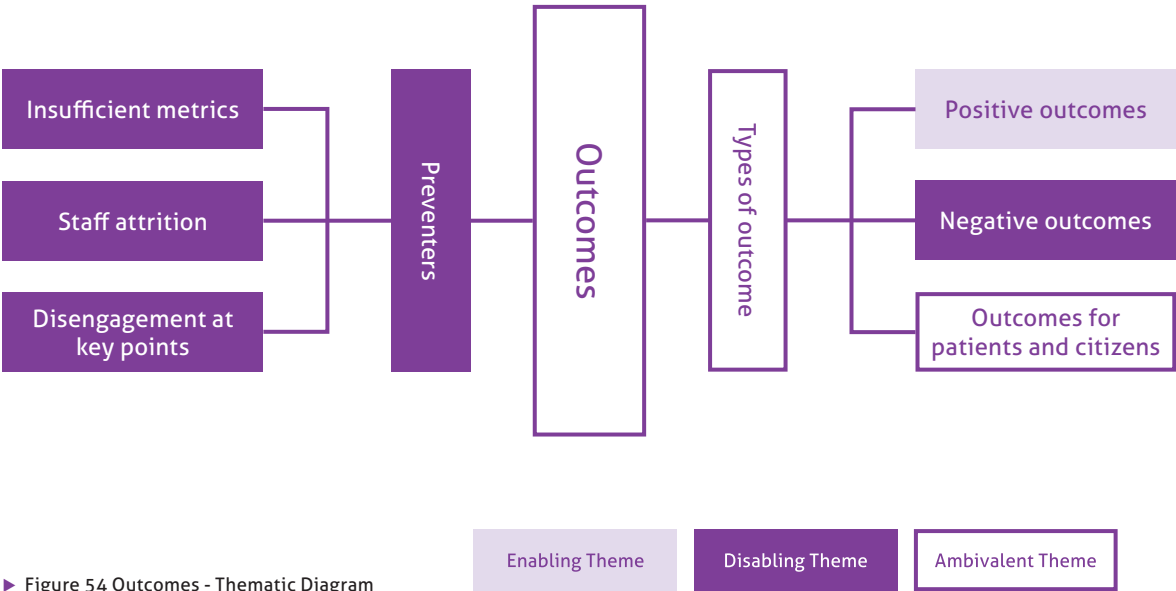
Conversely, far more positive themes all involved constructive dialogue between different organisations, or within organisations or activities.

- Changes in non-financial resource uses were very apparent from participants' interviews. This speaks to localised arrangements around what have been previously perceived to be systemic problems or gaps in service.

Evaluation Question:

What expected or unexpected impact is the vanguard having on patient outcomes and experience, the health of the local population and the way in which resources are used in the local health system e.g. equality?

8.1 Thematic Overview



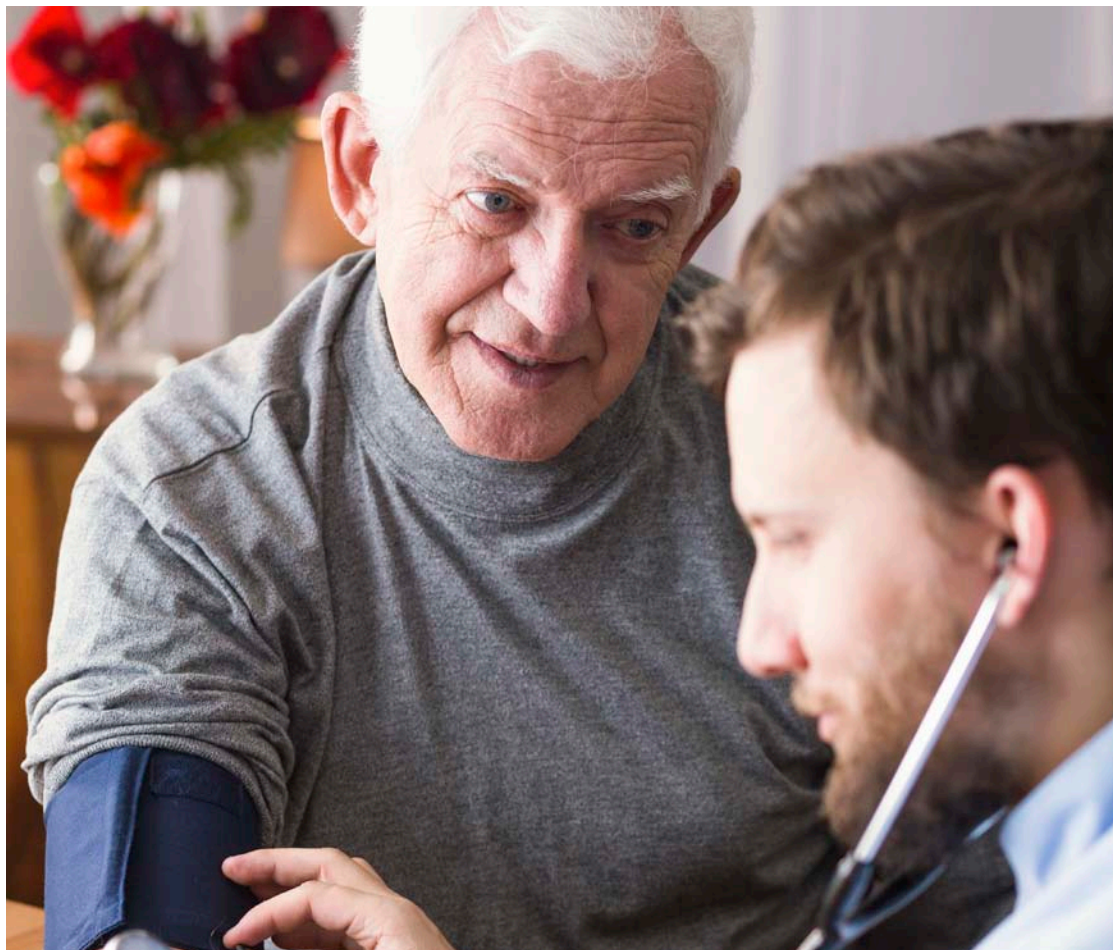
► Figure S4 Outcomes - Thematic Diagram

As discussed in Chapter 6, there was a strong sense across a significant proportion of participants that defining outcomes for the NCM was problematic. This was due to four clear reasons:

- The timescale it is likely to take for meaningful change to occur was longer than the amount of time that had elapsed;
- While positive change had occurred, the metrics currently being used by BCT to report outcomes were not capturing more tangible changes on the ground;
- Structural issues were preventing outcomes from being achieved (e.g. staff attrition);
- There was a lack of a clear sense of what the outcomes should 'look like' in terms of whole-system change. While the vanguard was supported by a logic model (see Figure 1), this was not referred to substantially by any participant during the course of the interviews. At the same time, other outcomes (such as the Triple Aims³⁷) were referred to, which served to complicate the sense of what the end goal of the NCM should be.

³⁷ See above, Chapter 1 Section 1.2

As might be expected, the themes from these two categories arise from the interlinking of a number of themes identified earlier in the C-M-O template. This interlinking is important for understanding the nature of both successful outcomes and preventers. For example, a preventer such as 'staff attrition' is clearly linked to earlier contextual themes around the historical problems of recruitment in the Morecambe Bay area. However, this is not the whole story: participants also linked attrition to the short-term nature of the funding, the amount of support from leadership, the lack of visible progress and anxieties about the future development of the NCM which may not currently be clearly articulated. In short, while the historical problem of staff attrition may be outside of the reach of a vanguard site to address, some other aspects of this preventer are.



```

graph LR
    subgraph Preventers
        subgraph Insufficient_metrics [Insufficient metrics]
            C1[Cultural change]
            C2[Longer-term change]
            C3[Sense of improvement]
            C4[Understanding costs]
        end
        subgraph Staff_attrition [Staff attrition]
            C5[Turnaround of staff]
            C6[Non-replacement of staff]
            C7[Project-based working]
            C8[Short-term funding]
            C9[Lack of support]
        end
        subgraph Disengagement_at_key_points [Disengagement at key points]
            C10[Lack of visible progress]
            C11[Lack of clear view of the future]
            C12[Lack of capacity]
            C13[Not 'around the table']
        end
    end

    C10 --- C14[Unconvinced by BCT]
    C10 --- C15[Insufficient metrics]
    C10 --- C16[Changes in strategy/focus]

    C14 --- Preventers
    C15 --- Preventers
    C16 --- Preventers
    C17[Unconvinced by BCT] --- Preventers
    C18[Insufficient metrics] --- Preventers
    C19[Changes in strategy/focus] --- Preventers

```

The diagram illustrates the factors that prevent BCT implementation, categorized into three main groups: Insufficient metrics, Staff attrition, and Disengagement at key points. Each group has several sub-factors listed to its left.

- Insufficient metrics**
 - Cultural change
 - Longer-term change
 - Sense of improvement
 - Understanding costs
- Staff attrition**
 - Turnaround of staff
 - Non-replacement of staff
 - Project-based working
 - Short-term funding
 - Lack of support
- Disengagement at key points**
 - Lack of visible progress
 - Lack of clear view of the future
 - Lack of capacity
 - Not 'around the table'

Additional factors listed on the left side of the diagram include:

- Unconvinced by BCT
- Insufficient metrics
- Changes in strategy/focus

► Figure 55 Preventers - Thematic Diagram

8.2.1 Insufficient Metrics

A common feature of participants’ comments on outcomes was the problem of how to record the kinds of changes taking place within the NCM.

There are simple measures like looking at the number of admissions, length of stay, all of those sorts of factors...But, I don't think they necessarily reflect on how efficiently that bit of the health economy is working. The more difficult bit is how do you measure the benefit of teams working together? How do we measure that; how do we get there? (INT022)

A lot of the things we're doing are culture changes. That's part of the issue. We're actually trying to do things differently. And the problem is that – what the CCG like are numbers. So, they want, “This month, you’ve accepted less Paediatric patients than you did last month. Tell us why, tell us what you’re doing.” But it doesn't work like that, you know. We’re talking about whole model change. (INT052)

The quote above captures a clinician identifying a clash between the demand for statistics as evidence of change, versus the evolution of change which is responsive, adaptive, and less statistically evident. For some participants, the long-term effect of the mechanisms being introduced provided an aspirational set of outcomes:

I think that the activities that are going to have the greatest value, for instance education, children, that sort of thing that’s going to change the way people view their health care and the health service, that’s going to have the biggest impact in the long-term. It’s going to be of greatest value, but it’s equally not something that we can evidence right now. (INT054)

But for others, there were already tangible outcomes taking place which they felt were not able to be evidenced at this point. For example, a care coordinator comments:

So my appointments are half an hour, so I’ve got time to sit and talk to people. So certainly, from a mental health perspective, I suspect that people get seen quicker, they get quicker treatment, they probably have better outcomes. I haven’t got any proof of that but I certainly know how many people I see and that it’s quite a lot of people. (INT051)

Given the importance of this kind of evidence, however, there is a clear need to identify whether cultural change is occurring, what may accelerate it and what may block it. Otherwise, problems will emerge (as some participants noted) with activities getting steered off-course from the main BCT strategy, progress not being visible (leading to frustration and/or potential disengagement), and progress not open to challenge.

In other cases, evidence is available, but the complexity of introducing efficiencies in finance and resource is more complicated, and involves a more nuanced approach to metrics:

I think it [BCT] is a more efficient way of working, I’m not sure that we’ve seen any cost benefit yet. We’ve seen reductions in non-elective admissions but that doesn’t mean to say we’ve been able to really take the costs out. In order to take the costs out, you’ve got to close wards or clinics or whatever, and we haven’t really been able to do that...because of the pressures on the system generally, and the backlogs that the Trust has got. (INT016)

8.2.2 Staff Attrition

One of the most consistent contextual themes to emerge was the problem of staff attrition as a key context for delivery. Some areas within the Morecambe Bay footprint have historically struggled to recruit to posts; while other participants commented on the short-term nature of the NCM contracts impacting on morale, quality and consistency of care, cohesion and trust.

Despite investing a lot of money in these programmes, we haven’t got the staff. And recruitment is affecting everything that we want to do. (INT063)

Case Managers have left, Nurses have left. You know, it’s been two years and they haven’t been replaced. And people have been quite nervous because the jobs have only been renewed for three months at a time [...] And that’s why with the Case Management team across the county, so many people have actually left. (INT045)

I’m one of the longest-serving members of staff here and I’ve only been here eighteen months. (INT057)

When I first started, I had a Case Manager and also a Band 5 Nurse. I’m a Band 4 so I’m non-clinical. I’m on my own. INTERVIEWER: The Case Manager? INTERVIEWEE: They left... [because of] Money and hours I think... she left after six months or so.... I had a Band 5 Nurse as well. She left. (INT049)

At the moment, we are not a full team as such. There’s only me and my colleague, the care navigator. We haven’t had a Case Manager for well over a year now. That’s been a bit difficult... (INT044)

Both clinicians and commissioners expressed concern about staff shortages and issues with recruitment and retention across the sector and its wide ranging impact on the continuity of care. From the perspective of the programme delivery, vacant positions in key areas and reliance on temporary workforce was identified as considerably inhibiting the implementation and progress of the BCT strategies.

I think it’s probably because there’s not enough staff to do it [integrate primary and secondary care]. I don’t think there’s a feeling of resistance from people not wanting to do it. We tried it for a little bit, with one of the Advanced Nurse Practitioners from the community, but it only lasted some weeks, before someone went off sick in their team, and they had to revert back to doing what they were doing before. (INT023)

Others linked this to the short-term nature of funding:

Staff are in post and even though they like the role, they like the job and they’re doing a good job, because they are not sure about the future and what’s in it for them long-term, they look at other opportunities. And we’re losing them half-way through the financial year... But then that leaves the ICC in a vulnerable position. (INT062)

We’ve had several Project Managers, and that lack of continuity has not helped at all... it’s a long-term project, it’s a long-term aim, but the money is all short-term. ... And also that doesn’t help with the work force, or with planning, or with what we might hope to achieve. (INT050)

Or uncertainty about the project itself:

I think because the service was quite new when the Case Managers were put in post, they didn’t quite know what the service was going to be and there’s been a lot of change. I think that’s probably quite hard to adapt to. (INT046)

There’s been some new role exploration, which I think we’ve done less well than we should have done and we’ve developed some new posts, where I don’t think we’ve put the support in to people... and we’ve had a level of attrition and a lack of attraction about some of those new job roles. So, I think we’ve not done that as well as we should have done. (INT058)

I’ve been close to leaving myself. When you’re struggling with a juggernaut uphill, it can be quite a battle. (INT048)

8.2.3 Disengagement at Key Points

One of the key preventers identified in the data was disengagement from practitioners. As with staff attrition, this theme brought together a number of sub-themes; some outside of the reach of BCT in and of itself, and others more clearly related to the delivery of the programme.

In Kendal, for example, there was scepticism in relation to the programme, being described as a part of the cyclical change noted within the NHS framed as attempt to ‘reinvent the wheel.’ Some participants from district nursing services saw no value of the NMC, describing it as a project- based initiative that will finish, and then be reintroduced under a different policy-driven initiative. These perceptions described the NHS in general (rather than the NCM specifically), and are likely to be similar to those themes described in Chapter 5 on contexts. They re-emerge at this point in the programme, however, if the mechanisms have not separated themselves enough from previous interventions. This is entirely possible, as the following quote suggests:

I’ve seen a lot of changes and a lot of initiatives, but this is the biggest potential driver for change that I’ve ever seen. I’ve always maybe been a little cynical on some of the management changes that the NHS has come along with, but I see BCT and ICCs as the biggest opportunity that has ever been presented for a radical shift to the benefit of all. (INT050)

Participant data analysis also evidences a wide-ranging disengagement with the programme in the strategic delivery of the NCM: slow progress, continuous changes to approach and service strategy contributes to wider disengagement from key operational processes. Here, staff lose motivation and interest in the programme when they “see the banners but disconnect with the substance”:

Classically when you have a wide-ranging involvement of operational staff in strategic thinking, and then nothing much happens in the next six months, there’s a high potential for staff to feel demotivated and disengaged from strategic processes...I think...the slow progress, the emergent circumstances that have led to different approaches, different strategies in the course of the BCT strategy, has probably disconnected the work force from what it’s all there for...I’ve heard reports that when you go onto a ward or...a community team, and ask about the BCT business, not many people on the ground really know much about it. They know the banners, they’ve seen all the publicity, but they don’t know the substance of what BCT is all about. (INT008)

As discussed above in Chapter 7, the availability of clinicians to contribute to strategic meetings was also a preventer for outcomes taking shape:

Even people who are meant to be on the Steering Group and the OOH group don’t turn up for the meetings. So if they’re not turning up for the meetings, they’re not having input and... we don’t know what they’re doing back in a Clinical setting, as to ...what actions they’re making with regards to the changes that we’re trying to make...People are overworked, there’s not the capacity there to do everything that we need to do. (INT008)

In contrast, participants from primary care and district nursing attributed the disengagement from the programme among specific groups in part to the engagement strategy at the leadership level. Participants reported marginalisation from access to information and a sense of resentment due to selective involvement of certain professional groups.

I know in [the ICC], where I usually work, the District Nurses weren’t invited to the ICC meeting initially. I couldn’t understand that...That doesn’t give out a good message, does it? (INT003)

This theme of having ‘the right people around the right table’ emerged in Workshop discussions as well. Participants from primary care, for example, often saw BCT as lacking clarity outside of hospital contexts. The hierarchical organisational structures and bureaucratic processes were seen to considerably inhibit innovation and motivation to introduce improvement at a delivery level. For example, General Practitioners may be able to implement changes in their own practice quickly, but aligning this with BCT means that:

it’s got to go to a meeting, then it’s got to go to a second meeting, then it’s a full business case, then it’s a third meeting and still no decision comes out, they get very frustrated and very reluctant to take part. (INT020)

The disengagement from the programme is not limited to individual actors within the system but includes entire sectors of health and social care provision. This involves withdrawal of Public Health and Social Care, identified to be a significant threat to the whole -system integration and multidisciplinary working. This has been attributed to the funding cuts in the local authorities having a direct impact on the service capacity and capability.

We haven’t got a joined-up system with them. And there are some things that both County Councils are facing. Reducing - cuts in their budgets, which...a real threat to what we’re trying to achieve. Because we need that multi-agency working. I suppose we’re trying to achieve system change, but if one of the elements of that system is actually being withdrawn at the same time - we don’t even know what cards are on the table properly, to move them around. (INT019)

Disengagement and withdrawal has not been limited to management structures, although frontline practitioners have attributed resistance towards the programme to the lack of understanding of underlying evidence, risk aversion and selective engagement of community- based services across ICCs at the commencement of the programme.

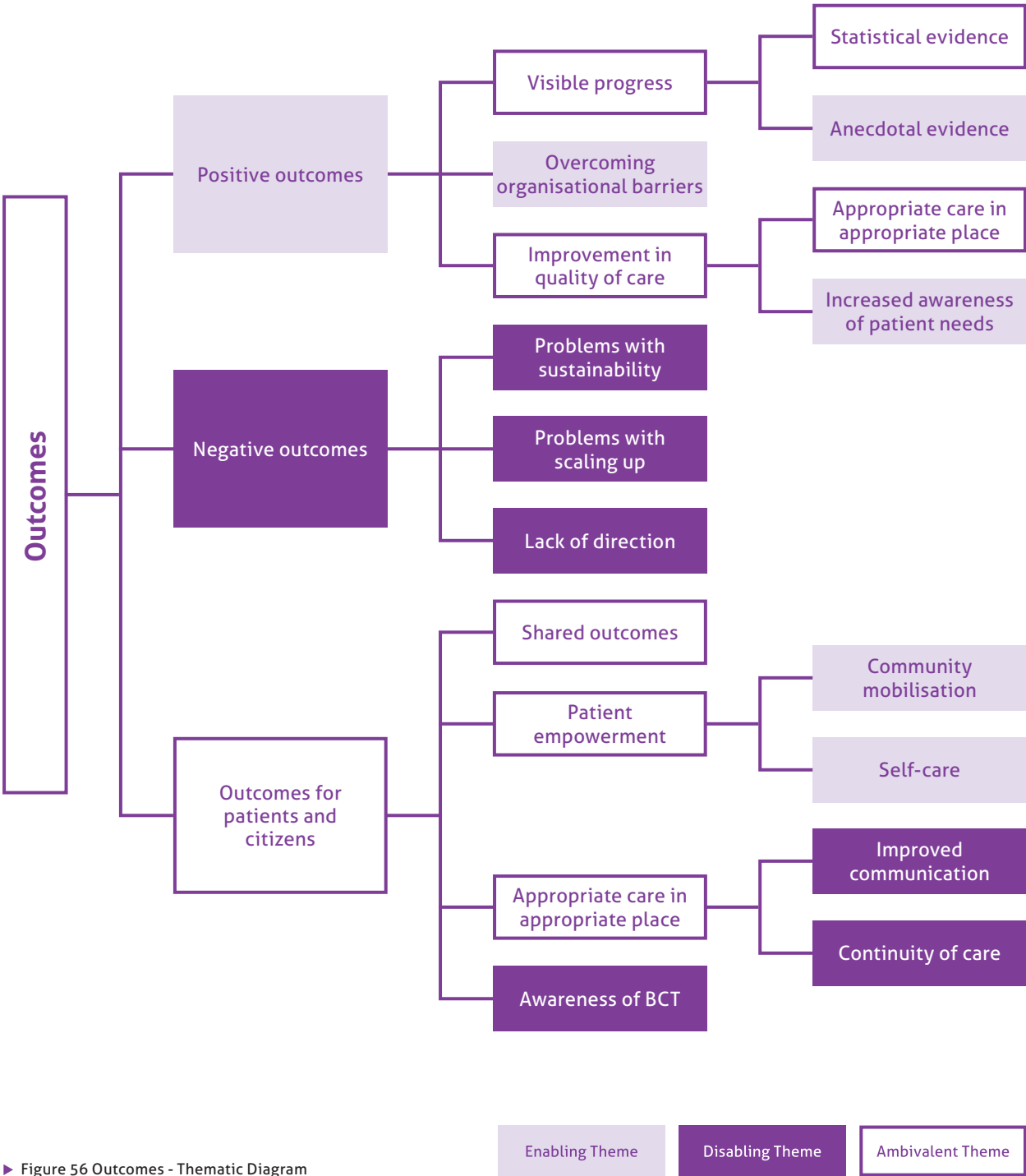
Most General Practice is really worried that what this [BCT] effectively means is an increase in their work load. So, some of them are very, shall we say, perturbed that ...some of these changes mean their work load could increase with no extra resource. Some General Practices just seem to have heads in the sand and just, “Nothing to do with me, not interested. (INT022)

A further negative outcome was the doubts about how much people in the other sectors understood about the BCT work and agenda. This in turn linked to the sense – often coming from primary and community care – that the strategic direction of BCT had been too hospital-focused to date. Thus, while successful work has been done in creating efficiencies from the hospital side, the knock-on effect on the community is harder to realise at the current moment. Participants expressed considerable misgivings about the overall strategic direction, the lack of clarity of the vision of BCT, and the decision-making processes at work.

What would be really useful would be for the more senior, the very senior management team, to make a true decision as to how we take this forward. (INT062)

I think within the NHS, we do a lot of project work, and people come in and support a project, then the project comes to fruition and those people withdraw, and it’s not fully sustainable. Some elements maintain, others may drop off. So somehow you need to maintain somebody to lead, to make sure it’s thoroughly embedded. (INT006)

8.2 Types of Outcomes



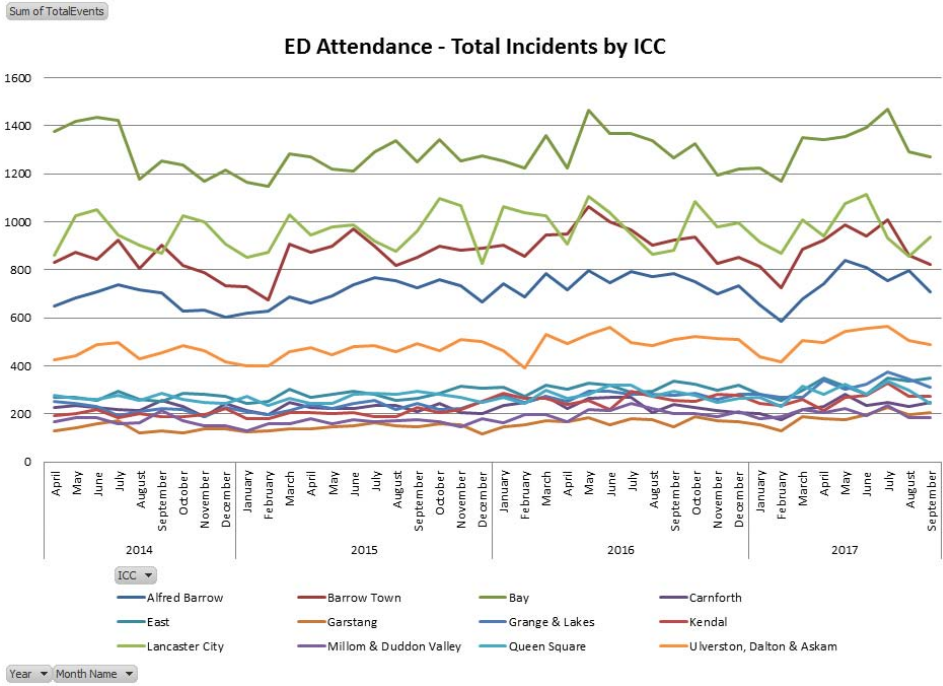
► Figure 56 Outcomes - Thematic Diagram

8.2.1 Positive Outcomes

The visible progress of BCT can be organised into two distinct areas. On the one hand, quantitative data should demonstrate the effects of the NCM after 12 months as a vanguard (although BCT has existed for several years before this). On the other hand, as noted above, much of the more incremental progress was typically anecdotal, and many of the changes made qualitative in the first instance.

In terms of reporting on visible progress in the quantitative data, this report will not reproduce the work done by the quarterly reporting metrics supplied by UHMBT Business Intelligence. This has shown a significant decline in non-elective admissions and non-elective bed days, as Chapter 7 discussed. Instead, the evaluators looked at the quantitative data available to look for how outcomes might be identified that would demonstrate the effect of the qualitative causes discussed in Chapter 6. This involved analysing the data by ICC area, in order to identify any notable differences in outcomes between sites.

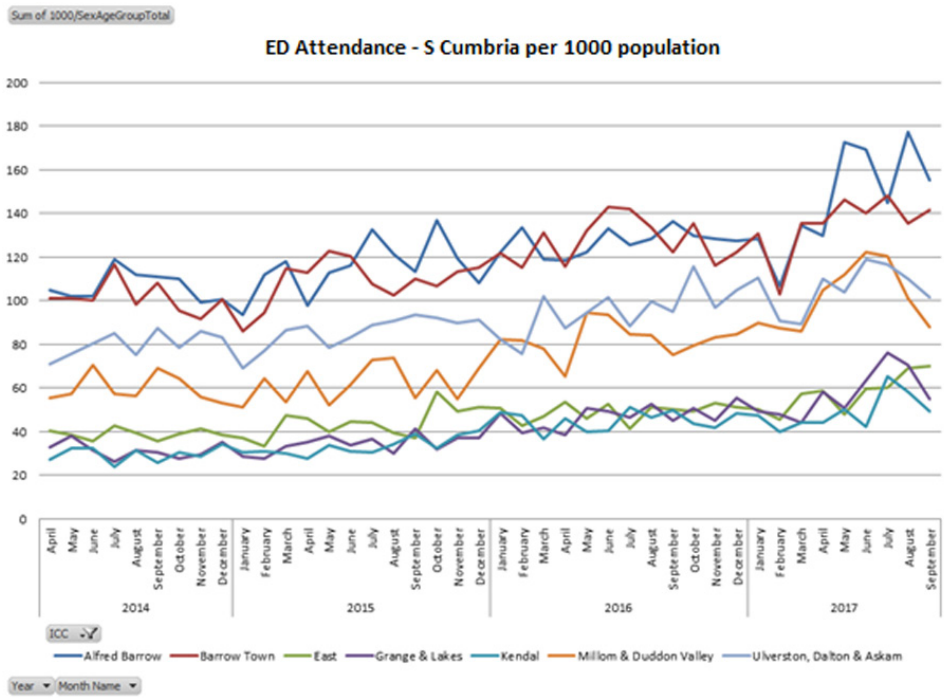
Some outcomes of this form of analysis have been shown in Chapter 7, in terms of cost reduction. Looking here at ED attendance totals, we can note that the highest scorers are, perhaps somewhat predictably, those with the highest populations (Bay, Lancaster City, and the two Barrow ICCs).



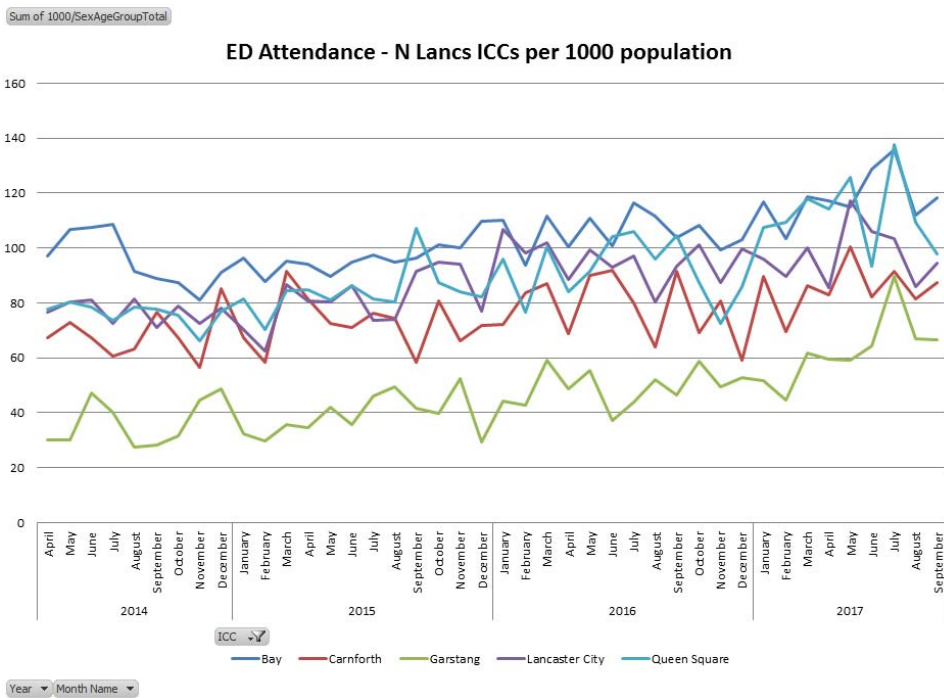
► Figure 57 ED Attendances - Total Incidents by ICC, 2014-17

Total incidents alone, then, will reflect some obvious disparities between ICC populations. For a comparison between ICC areas, the following figures are based on total numbers per 1000 population. Comparing ED Attendance by ICC areas in this way allows us to see if any area is showing a significant difference in relation to others, which would in turn enable the qualitative changes within each ICC to be represented as outcomes.

For visual clarity, the charts have been broken down into South Cumbria and North Lancashire ICCs, and the chart begins in 2014 to roughly coincide with the beginning of Better Care Together (rather than October 2016, when the vanguard funding began). This is a comparative chart, to look for differences in regions; this is not to be confused with total frequencies, which are (somewhat naturally) far higher in the more densely populated ICC areas.



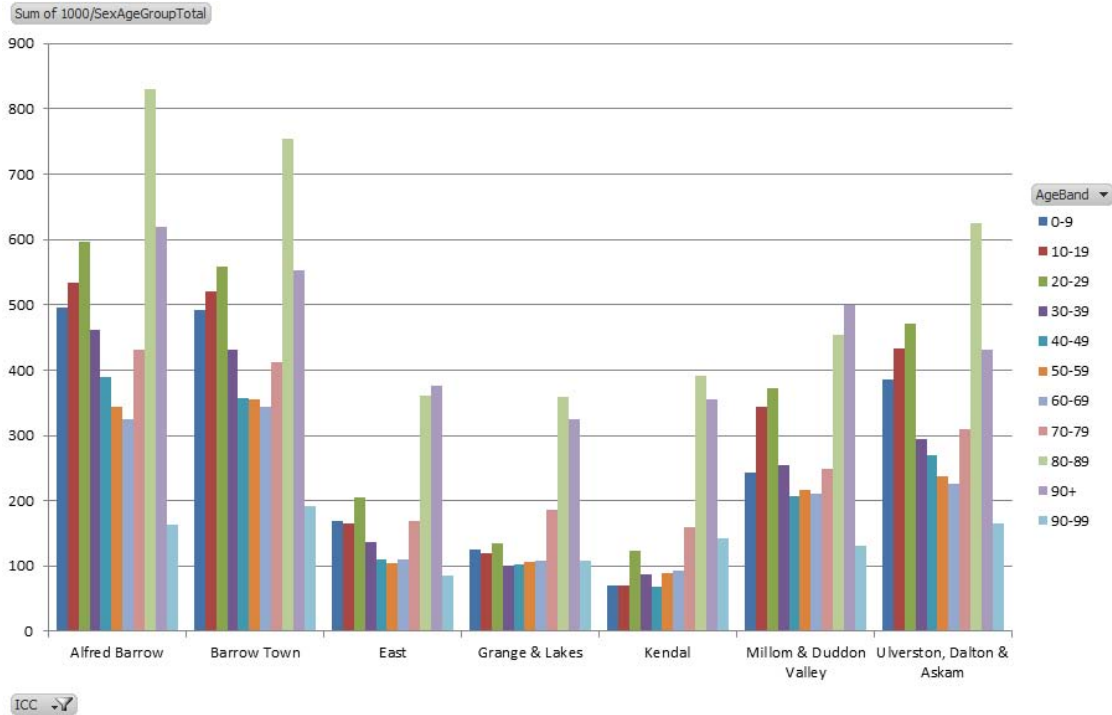
► Figure 58 ED Attendance - S Cumbria ICCs per 1000 population



► Figure 59 ED Attendance - N Lancs ICCs per 1000 population

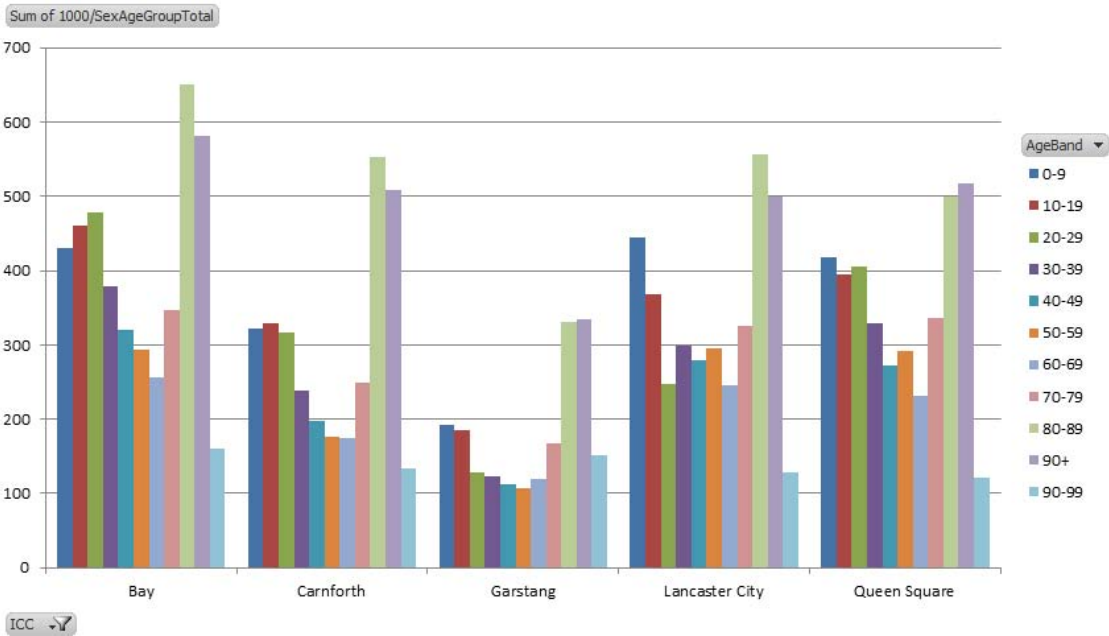
One observation to make on these figures is that in South Cumbria, frequencies seem to separate with some regularity across the ICCs, whereas, with the exception of Garstang, there seems to be no separation between the frequencies of ICCs in North Lancashire. There may be several reasons for this.³⁸ For example, the higher scoring ICCs in South Cumbria are closer to Furness General Hospital, which has an A&E department, while Westmoreland General Hospital in Kendal has an Urgent Care Centre. Due to the overlapping boundaries of the North Lancashire ICCs, meanwhile, the distance between an ICC and Royal Lancaster Infirmary’s A&E is less straightforward to separate, which could be reflected in the frequencies. Garstang ICC is an outlier for all hospital-based metrics, most likely due to its proximity to the Royal Preston Hospital (outside of the BCT footprint).

An alternative explanation for the differences in frequencies may be the age demographic within each ICC. If we compare ED attendances between 2014 and 2017 by age, then there is a clear difference per 1000 population between the Barrow ICCs and East, Grange and Lakes and Kendal for the age groups of 10-29 and 80-90+; both of which are the highest ED attenders on average across the piece. In North Lancashire, meanwhile, the age groups are more evenly distributed across ICCs.



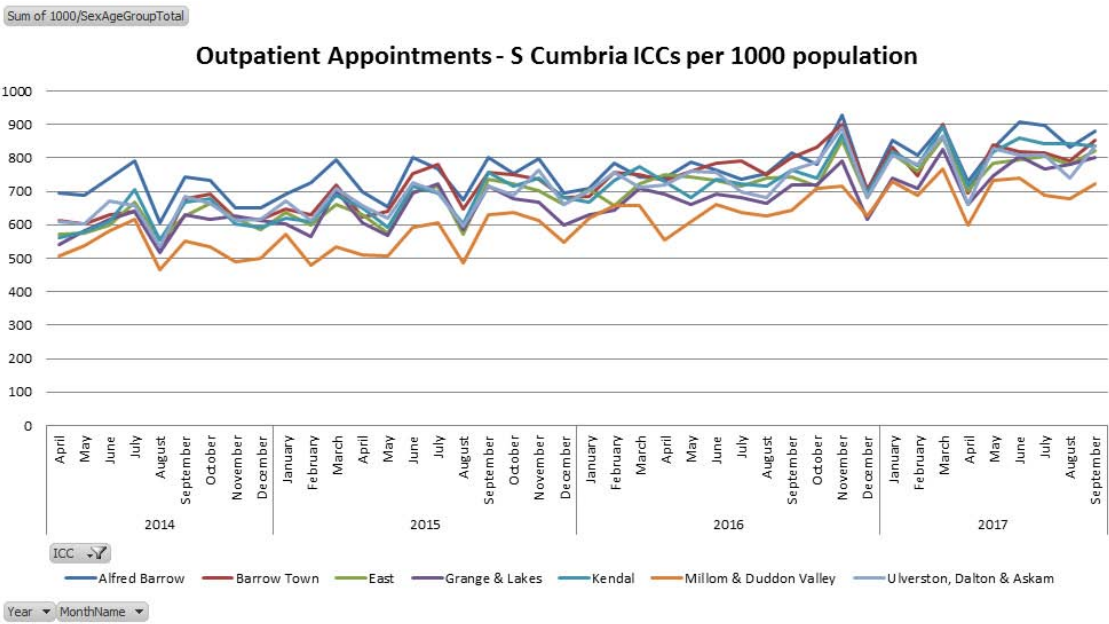
► Figure 60 ED Attendance by Age – S Cumbria per 1000 population

³⁸ Chapter Two has discussed some of the methodological problems with working back from high-level outcomes to localised causes; these are all relevant in this case.

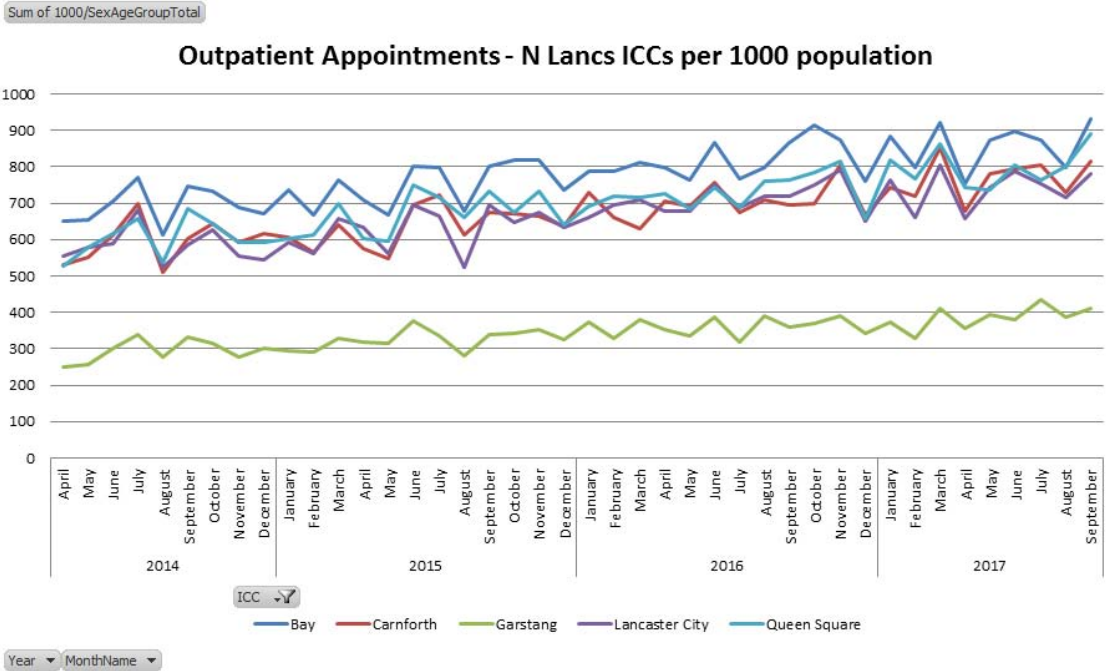


► Figure 61 ED Attendance by Age – N Lancs per 1000 population

A more decisive pattern emerges when we apply the same per 1000 population comparison to Hospital Outpatient Appointments. Again, we use data from 2014 in order to contextualise the outcomes appearing after October 2016, and the addition of vanguard funding.



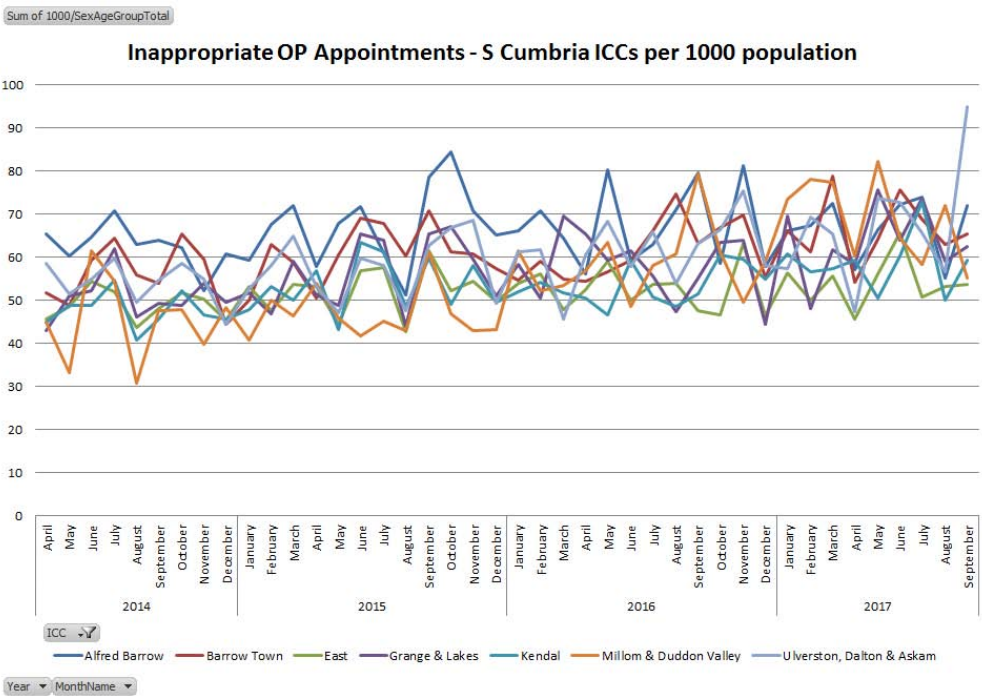
► Figure 62 Outpatient Appointments - S Cumbria ICCs per 1000 population



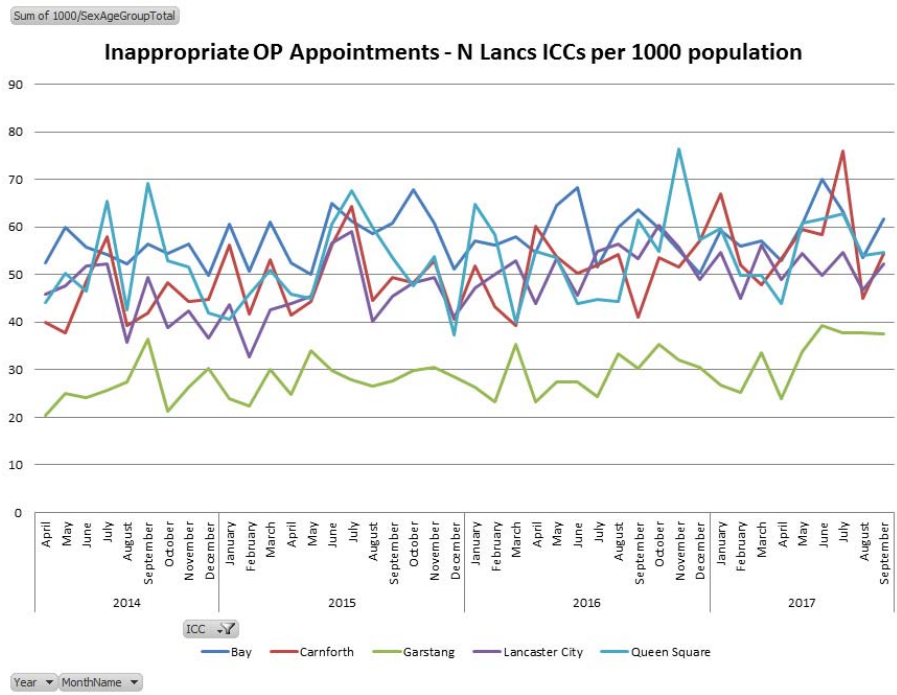
► Figure 63 Outpatients Appointments - N Lancs ICCs per 1000 population

Per 1000 population shows that there is no clear difference between the ICCs in terms of numbers of overall outpatient appointments, and remarkably similar trends. The only outlier here is, again, Garstang ICC. With the same comparison run for inappropriate outpatient appointments (new OP appointments with an outcome of discharge/discharge (treatment complete), the picture is decidedly less clear:





► Figure 64 Inappropriate OP appointments - S Cumbria per 1000 population



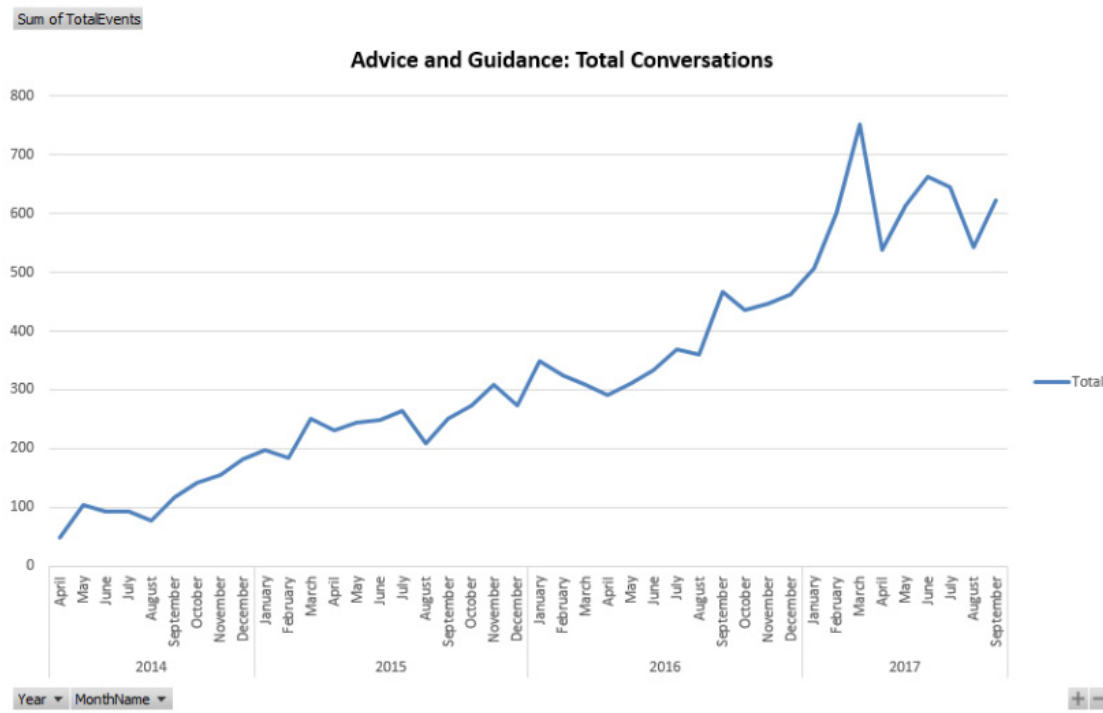
► Figure 65 Inappropriate OP appointments - N Lancs per 1000 population

When comparing outcomes across ICCs, it would seem that participants (in both interviews and the outcomes survey) were justified in suggesting that it is too early to see visible change on a broader level. The main differences between areas of Morecambe Bay can still be attributed to contextual factors outside of the BCT.

A more nuanced examination of the data could be undertaken (e.g. breaking down outpatient attendance by speciality, and monitoring those within vanguard workstreams). There would remain problems with this approach, however, when triangulated with qualitative findings. Not all activities within workstreams have become operational, which would make discerning the effect of vanguard activities from non-vanguard activities difficult. A form of projection for when workstreams would expect to see effects would also help to provide a stronger sense of how the outcomes related to vanguard activities. For example, there is a notable drop in ED attendance immediately following the vanguard funding; but this would clearly be far too soon for funding to realistically take an effect on patient activity.

As the ICCs continue to develop, a more sophisticated system of flagging individuals who are within the scope of specific interventions and pathways may be possible. Given that the main changes at work in the NCM are fundamentally about integrated care, this would be a more reliable metric for measuring both the success of the programme and the benefit of investment.

A more straightforward alignment between qualitative changes and quantitative frequencies can be seen around the theme of dialogue, which was discussed in Chapter 6. The Advice and Guidance system, for example, which allows GPs to communicate with Consultants in order to assess whether patients need to be referred to the hospital, is one BCT initiative which shows how such conversations can have a significant effect on hospital admissions.



► Figure 66 Advice and Guidance: Total Conversations BCT-wide

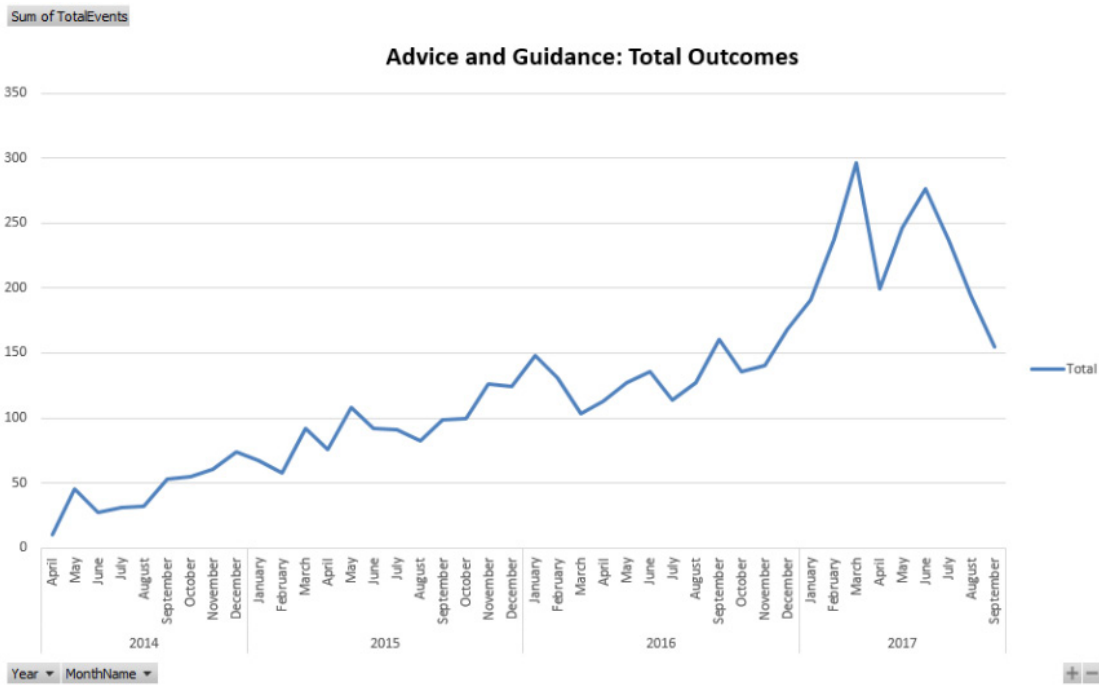


Figure 67 Advice and Guidance: Total Outcomes BCT-wide

The figures above detail the total incidents and outcomes for the system (total frequencies are shown because this initiative is separate to ICC-specific work). 'Outcomes' here refers to patients that would have been referred to Outpatients but, following the Advice and Guidance conversation, were managed elsewhere.

On the one hand, looking at these figures from 2014-2017 suggests a narrative whereby closer working between primary care and hospitals is resulting in a reduction in Outpatients appointments. But at the same time, it should also be noted that following a relatively steady progression between 2014 and 2016, the results are visibly more volatile across 2017 (in particular the second half of 2017, where outcomes deviate from conversations). As before, there are a number of possible reasons for this, and to attribute causality reliably to the NCM it would be necessary to test hypotheses of change, based on the qualitative themes and quantitative metrics, rather than draw firm conclusions from the outcome figures alone.

If the higher level outcomes are still in development, in contrast a number of participants could identify tangible outcomes of the work of BCT, but also noted that success – in particular success in proactive care and improvements in self-care, which would take longer to take an effect on hospital attendance – was based on incremental, small-scale change.

It's been very successful in some parts, particularly where I've got to know a patient in my community that's gone into hospital, if I know them really, really well then I can ring up and say, "I know that patient, that's baseline for them, can they come home today?" And on a few occasions, that has happened, so I have made a difference in for a lot of things, particularly for things like Mental Health it's been brilliant. With that we've - actually what we've been able to do with that, we've been able to focus on some of the non-attenders. (INT052)

Some progress was seen simply in terms of overcoming organisational barriers, and evidence of engagement of different care providers and multidisciplinary partnerships between healthcare professionals. This integration has been reported to lead to a more consistent approach with established communication channels and more joined-up service provision. In particular, the setting of clear and agreed goals was paramount to the success of these conversations:

I think we've had a lot of successes, we've got really good involvement from both community services and from the Trust and from primary care, and we feel that we're really starting to make progress now in those areas. So, we're having a lot more joint clinical discussions between consultants and GPs and they're actually now trying to work towards the same goals. (INT001)

And in others, this was linked to successes in organisational culture change:

It will be at least another five or six years before we've got that buy-in how we want it. But, we're starting to see the "I can do", instead of "that's not my job." (INT063)

Participants often struggled to identify evidence of incremental changes on the ground that would show the success of interventions. This was most difficult in those areas aiming at proactive care, rather than the re-adjustment of existing pathways. Nevertheless, the importance of seeing change – whether this was able to be mapped on to higher-level metrics or not – was crucial to the enthusiasm for the project:

The positive is that despite all the meetings, you can actually see movement and the development of something really exciting. The ACS, the accountable care system, if we can get to that stage and align as a system, then that would be absolutely fabulous. (INT061)

Receiving healthcare at the most appropriate settings supports system efficiency via reduction of unnecessary admissions and duplication of services was identified as a key improvement in the quality of care, both in terms of improving patient flow and healthcare outcomes.

We should be beginning to achieve a reduction in people needing to go to hospital, for things that don't need to be done in hospital...And I suppose linked to the only going to hospital when you need to, is an element of getting what you need sooner, and where you are. So hopefully not progressing, but getting a quicker response that actually meets the needs. (INT019).

A number of staff involved in MDTs noted that the increase in communication formed the bedrock of improved quality of care for patients:

There's also been the Orthopaedic surgeons who have been working on the project -- actually it's quite interesting - they've changed the way they've viewed management of MSK problems... And that has been a great result that we never envisaged happening. (INT029)

I think also it's empowered a lot of the physios, because even the physios not working as part of the team know that it's happening. The fact that their colleagues are working and seeing patients who would otherwise be seeing Orthopaedic surgeons is empowering to them as professionals. Feeling that what they do really makes a difference, which I think is excellent. (INT029)

As has often been the case, due to the early stages of the some of the projects, the perception of improvement was balanced between evidence and expectation. Other participants raised the issue of how scalable some of the initiatives were (see below, 8.3), and there was a clear sense that in some areas MDTs had been far more difficult to set up than others, due to factors described above in Chapter 6.

As the quantitative metrics above show, there has been a significant decline in non-elective bed days and non-elective admissions. While it is not possible, on the current data, to suggest a firm cause for these reductions, participants in primary care did note that mechanisms introduced by BCT were contributing to a wider range of possible outcomes for patients other than visiting the hospital.

Well I would say we certainly have more options now, rather than admitting people. There are some other...provider teams...where you have access to a physiotherapist or an occupational therapist...The majority of the time they [older patients] were getting admitted for social reasons, because they were unstable, with nobody to care for them. Now you have other things that can step in and do that. And that's part of us working together. (INT025)

This corresponded to an increased awareness of patient needs: something enhanced by the success of MDTs and bringing in different professional viewpoints.

8.2.2 Negative Outcomes

At the same time, the significance of the impact was not always guaranteed. In one workstream, the outcomes of the project were framed in terms of lack of anticipated outputs and impacts: observed changes were small in magnitude with no significant impact on the wider system transformation. The lack of wider impact of the programme was directly attributed to dysfunctional leadership.

So I think there will be a few patients who will have had slightly quicker appointments, there will be a few patients who've had some interventions done slightly more quickly than they would have done, but I don't actually think there's a huge, wholesale change in the delivery of Cardiology services in Morecambe Bay. That's not to say there couldn't be, and I think if it was under a different guise, and a different way of framing the work, I think it could be different. (INT020)

This theme linked to others raised around the project-based nature of the NCM. This raised a tension between the delivery of small-scale pilots, and the possibility of developing them into long-term sustainable and system-wide changes. One participant, for example, argued that the current developments remain largely vulnerable owing to the fact that they are still being seen as time-limited schemes as opposed to new approach to practice.

There are quite a number of projects, that have been started and have been quite successful, but the question is: how do we scale those up so it becomes the norm across the whole of Morecambe Bay?...And they're still seen as projects, rather than a new way of working. ...I think there has been some progress... [But] whether that is sustainable is another matter. (INT018)

As discussed above in Chapter 6, the principles of the NCM is present in much of the data; but the lack of milestone markers from beginning to an end can be a disabling factor in monitoring progress, and ensuring that initiatives produce outcomes within a given timeframe.

What I think have probably let it down [is] the sense that, a nice piece of work would have a beginning, a middle and an end, and it does feel a bit headless, at the moment. (INT008)

In this sense, the vanguard interventions remain localised solutions which struggle to be scaled up without further investment.

ICCs pose a particular challenge, in this sense, because on the one hand the lack of direction associated with a 'bottom-up' approach is intentional and consistent with population focused care; yet, this kind of operational flexibility adds to complexity of the programme implementation, delivery and the sharing of good practice. Hence, one participant commented:

it needs to be more centrally coordinated [...because] there was a disparity between [the two CCGs and the two OOH work streams] that they were two completely separate organisations going completely separate ways, with the hospital Trust in the middle trying to meet the needs of both, and potentially failing in all avenues. Then the various work streams that cross-cut everything and it just seemed to be a bit messy. (INT006)

8.2.3 Outcomes for Patients and Citizens

Outcomes for patients emerged as a key theme within the staff interviews. It was not clear from the interview data how much evidence was being collected systematically by staff on patient responses to the interventions. In some cases, the improvements in patient care were assumed with reasonable justification. In other cases, such as Ophthalmology and some Paediatric interventions, initial patient feedback was from follow up phone-calls to patients by the co-ordinator. The responses from these (some of which are documented in PDSAs) are generally positive; although there does not appear to be a consistent approach to garnering patient feedback.

Alongside staff views of what outcomes were, or would, be happening with patients and citizens, the evaluators held focus groups with patient groups. These focus groups were purposively sampled to reflect the focus of the 2017/18 evaluation work. As such, they came from the three geographical areas that will form the focus of the 2017/18 evaluation (Barrow, Bay and East ICCs), and/or groups which would potentially be affected by the pathways under examination (respiratory, paediatric and frailty).

While this resulted in a wide range of participants, there were some surprisingly consistent themes to emerge in response to the mechanism and outcome themes that staff and other stakeholders raised. The emerging themes are organised below.

Patient Expectations, and Expectations of Patients

Understanding patient expectations (in as localised a context as possible) is key to demonstrating the success of BCT. Patient expectations may well not necessarily coincide with clinical views. Alongside this, a condition of the longer-term success of BCT is the empowerment of patients and mobilisation of community resources (although, as discussed briefly in Chapter 2, the role of this mobilisation is not always tracked in a theory of change).

In general, both service deliverers and patients shared similar expectations about the outcomes of BCT initiatives. The fact that patients were seen closer to home and there were timely appointments, for example, were considered good outcomes by staff:

In Millom we're using telehealth, so they're not having to do that really tough 50-minute journey on a bouncy road with one way in and one way out. (INT061)

From a patient experience perspective, they don't have to travel. As you know, we are a community quite wide reaching geographically, and that has its own challenges, which means that actually in reality, a patient can be seen in the high street down the road, rather than travelling to one of three hospital sites, in order to be seen and treated and to be sure that everything is okay. So from a patient experience perspective, I would say that's a success. (INT041)

They don't have to travel to hospital and wait for hours to see a Consultant to have something minor dealt with. (INT035)

The patient focus groups conducted tended to agree that while being treated out of hospital was preferable to inside, the time taken to wait for an appointment was a significant issue, and a recurrent cause of frustration. Some participants identified being sent to different hospitals across the Morecambe Bay area, which could have costly travel implications. Others noted that travel had become a problem since General Practices merged and services were redistributed.

PARTICIPANT 29: It's getting an appointment at the right surgery. You're by your house, where there's a surgery and then all of a sudden, they're all intermingled and they want to send you up to Heysham when I live at [redacted – 2.8 miles away]. It's either two taxis there and back, two buses, because it's too far to go on my scooter. They wanted to send me up to Heysham and I refused.

This, in itself, is a separate causal factor from the NCM. But at the same time, in some cases key terms for the NCM, such as 'integration of care', were interpreted by patients as introducing unnecessary travel rather than reducing it, because the phrase was associated with the number of recent mergers of GP practices (this theme was also picked up in the Outcomes Survey – see Appendix Six). When asked what changes they had seen in local health provision, one participant noted:

PARTICIPANT 16: Yes, they've all merged and we've got this massive conglomeration of doctors now, so I've heard of people having to go through to Lancaster [from Morecambe]. I'm taking my son this afternoon, I'm having to go to [redacted]. I've never been to that -- you know, it's not far, it's just having to go to a different place every time. That's a big change.

PARTICIPANT 9: Well it has seemed that I've been sent to more different places this last year. It's becoming more of a thing. I was at Lancaster hospital myself, and there were a couple who'd come from Kendal and it had cost them £47 in a taxi. Then obviously they've got to go back, so it would cost them £100 to visit the hospital.

In this sense, the ambition of patients being seen at appropriate times and in appropriate places was placed within a disabling context of service reorganisation.

At the same time, patients with more complex needs also expressed a consistent willingness to travel out of area to address their care needs, suggesting that travel was not necessarily the biggest concern; whereas appropriate care was:

PARTICIPANT 11: I go to Preston hospital quite a lot, under the care of a neuro-surgeon and I can honestly say I have waited at the longest 15 minutes in the past five years... I really think that because it's another teaching hospital and it's out of our area, it comes under another body, doesn't it?

PARTICIPANT 7: My friend chose to go to Liverpool, or somewhere. Then you've got to get there, which can be traumatic sometimes, but you go to the best place for what you've got ailing you, perhaps.

Patient Empowerment and Community Mobilisation

A key reason that a more systematic, ongoing evaluation of patient views is an important issue for understanding what 'works' in the NCM is that one of the guiding principles of the vanguard site involves moving towards a more empowered and educated public. In line with the move towards a whole-person approach to care, with a focus on localised, population-based delivery, many participants raised the theme of patient empowerment.

I think the patients really appreciate it. I think they're made to feel individual and special and listened to... whereas if you come and see a Doctor, it is just about your medical problem. You get ten minutes, you know. When you go and talk to them, they can tell you everything that's going on... (INT047)

I think more than anything it is empowering the patient. A lot of the patients didn't know that this service was out there... some patients are just so relieved... "If I'm struggling, I know who to ring now." And just me actually leaving that card, gives that person, the patient, the empowerment just to be able to contact us whenever they're struggling. (INT045)

This point about having a clear point of contact was also picked up in patient focus groups, with varying results:

INTERVIEWER: It's just getting to that point [of a single point of contact]? PARTICIPANT 9: It's getting to that point, yes. Since then, I actually had somebody phone me yesterday and he said that my point of contact was going to be him. If ever I was worried about anything... it's him I would speak to. That's good... That you have got that contact with somebody who knows what's going on.

PARTICIPANT 17: There's no continuity of care again. It puts you off ringing up, because you never know what time to ring up for an appointment, you never know what number to ring up for an appointment. You don't know where you're going to get sent.

Patient empowerment, however, is complicated. Often, participants tended to group 'informing the public' with 'empowering the public'. Educating the public about self-care, for example, is not identical to co-production of care; and this became a grey area in much of the data (see Chapter 6, Section 6.4). Conversely, the two comments above from care coordinators could well reflect an improved service provision (which would link to the identification of gaps within the system) and, a shift to a more social model of wellbeing.

Conversely, the participants from self-help groups identified these as key enablers of improving their health; one participant noted that they had had a COPD appointment rescheduled for the same date as their self-help group, and chose the group over the clinic. The consensus from all the focus groups indicated that community assets are important in meeting needs and these can address isolation, frailty and low mood; community groups/centres provide a focal point for support, these assets help foster friendship and can provide signposting to key resources. As one participant noted of their particular group "It's like AA for breathing." (PARTICIPANT 9)

While the forms of care that the groups facilitated – very much in keeping with the broader understanding of wellbeing discussed in Chapter 6, Section 6.4 – were identified as crucial to improving self-care:

PARTICIPANT 2: ...it's isolating. When you're ill, you can't get out.

PARTICIPANT 38: I live in a ground floor flat and last week I was struggling from walking from the bedroom to the kitchen. Because I lean forward, if I'm struggling to breathe I put my hands on something and I lean forward. It does seem to get my breath regulated. But there's no one you can phone up when you're feeling like that.

It became apparent in several focus groups that support and information-sharing was perceived to be taking place in spite of some health services, rather than alongside it. In some cases, particularly around areas of mental health, gaps in services relating to aftercare, support and diagnosis had left patients isolated:

PARTICIPANT 21: That's when we get left to Google.

Whereas a more common narrative across the focus groups was based on community assets:

PARTICIPANT 14: Just go on Facebook and ask other parents that we know through the support groups that we mentioned before. That seems like the easiest option, then they give you advice and you take it from there.

PARTICIPANT 15: I feel that the support I've been given is by charity organisations. ... It was the charity organisation that helped me [redacted: with aspect of child's condition]. Whereas that should have been the Consultant's job.

PARTICIPANT 15: There's networking as well that goes on through schools, with your children. They go to similar schools and have similar difficulties. You've networked from there and then other parents have opened you up to other places, organisations that can help. INTERVIEWER: Yes, but I'm getting a sense that it's very much removed from the healthcare system. It sounds like it's – PARTICIPANT 17: They look after themselves. PARTICIPANT 16: They fend for themselves or network through friends and charities and the other community support, but the healthcare tends not to be joined up with all that.

PARTICIPANT 15: I'm learning about it myself and I've had to go to charity organisations to learn about it and other parents who have a child with that same condition and I'm having to tell the health professionals about it when I'm still learning myself. I just got a diagnosis. There, he's got that.

Although some groups identified clearer links:

PARTICIPANT 2: We get speakers, sometimes from the hospital, the respiratory Nurse and the therapist. Even the Consultant on occasion.

It is worth bearing in mind at this point that these groups were purposively sampled, but had not necessarily had direct contact with BCT initiatives. As such, these comments are not necessarily representative of the patient population. Rather, in terms of the delivery of BCT, these themes raise two specific issues. Firstly, they confirm what a number of initiatives have already pointed towards regarding the need for better sharing of information and expertise to support citizens outside of clinical settings, and promote a broader understanding of wellbeing. Secondly, they suggest that this is not currently perceived to be happening, even if the ethos of BCT initiatives are resonating with patient concerns.

PARTICIPANT 16: I don't think a lot of doctors know, even though they've been to university and they've done their thing, I still think a lot of health professionals are uneducated about learning difficulties, autism, everything. It just seems to be like you're having to educate a Doctor.

PARTICIPANT 1: They admit to you, we'll try this and then we'll try that. Surely, they can go to somebody that is more experienced [in respiratory] than them and get a bit of advice.

It is worth noting again at this point that these participants had not necessarily been part of specific BCT pathways; in the 2017/18 evaluation, where patients who have been through BCT pathways will be interviewed, this will provide the potential for a clear comparison between the two groups.

Communication and Time

One of the main themes revolved around communication and the time available for clinicians to engage with patients.

PARTICIPANT 8: I think that if you are listened to is really important. Especially for your first consultation. PARTICIPANT 2: Enough time as well, to explain what your problems are, without being shoved out of the door.

PARTICIPANT 5: I think just having time, not making you feel as if -- letting me say what I want to say.

PARTICIPANT 24: ...they don't always listen to the patient. They think they know what's best and they don't know what's best for that particular patient.

Where participants had positive stories to tell about the services they had received, time and communication were crucial aspects of their experience:

PARTICIPANT 6: All I've had has been good. I had a [respiratory] flare up once and the Doctor came the next day. He sat with me for ages and I said about dialling the numbers, you know. You can't think straight when you're trying to breathe, can you? He said, don't bother about it, just dial 999. So, the next time I had one, I dialled 999 and the woman at the end was brilliant, because I couldn't speak and I was just gasping, and she seemed to know what I meant, what I was saying. They must have been just around the corner, because within minutes they were there. That was brilliant. I can't say anything detrimental. They were brilliant.

Perhaps the largest frustration to emerge was with the time taken to get appointments:

PARTICIPANT 3: Also, not waiting too long for your appointment [would be an improvement]. That's another big thing, because it can work you up.

INTERVIEWER: Have any of you noticed any changes in the way your care is being provided over the last year, or maybe over the last eighteen months? PARTICIPANT 41: Well I can't make appointments. I can't get appointments. (Sound of general agreement across the group)

Some participants noted that the difficulty in getting seen in clinical settings could lead to being 'put off' trying. Instead, other services were utilised, such as pharmacists.

PARTICIPANT 15: I feel reluctant to go, as well. Sometimes I will go to the chemist and just get what I need from the chemist and try that first and try and put off going to the doctors, because you can't get an appointment.

In this sense, the work being done within the NCM to create more alternative or midpoint services, and address gaps in service provision which address patient-centred care, would seem to resonate with the concerns raised by the patient focus groups. There remains something of a communication gap, for these participants at least, between the move to a broader approach to health delivery (whereby visiting the chemist may well be more appropriate than visiting the GP), and the perception of a health system working against, rather than for, the patient. This theme is picked up below, under 'Awareness of BCT.'

Continuity of Care

Continuity of care was a consistent theme of concern throughout the focus groups. Frustration at the lack of consistency with care received underlay a number of pertinent issues for participants, including: having to see different doctors on each visit; having to repeatedly provide verbal account of health history or child's disability; confusion about procedure for making appointments. This leads to stress, wasted time in the consultation and despondency with health services. Lack of aftercare after diagnosis of a mental health disorder also emerged as a highly emotive issue.

Participants expressed the need to feel understood and cared for as a whole person.

PARTICIPANT 27: You're not a patient now. ... INTERVIEWER: What do you mean, that you're not a patient? PARTICIPANT 27: Well, you're only a number, aren't you? You don't have the continuity of anything. You just go, and I don't seem to be able to get anywhere. PARTICIPANT 26: You want your family Doctor back again.

The idea of wanting 'your family doctor back again' was expressed by older participants; but while focus groups around paediatrics also expressed a need for a single point of contact, a number raised issues around the GP role, and the appropriateness of a generalist dealing with complex conditions. In some cases, this could lead to frustration:

PARTICIPANT 13: It’s like they [GPs] don’t listen to you either. You tell them and then they just sort of ignore you, and tell you what they wanted to tell you, rather than listening to what you’ve got to say to them.

The need for a single point of contact was not, then, necessarily about returning to the model of a ‘family doctor’, but rather about enabling the quickest line of communication between patient and clinician as possible. This was supported by the widespread dissatisfaction from participants around having to recount their medical history at successive appointments; hence, continuity of care and seeing a clinician who knows their history was valued by some participants as a way of reducing anxiety.

PARTICIPANT 27: You could get fobbed off with the locum, who doesn’t know any information about you. You’ve got to sit there and tell him everything. Whereas when you can go to see your own Doctor, he knows everything about you. You don’t have to keep going through it all.

On this note, some questioned why patients’ records are not comprehensive – particularly when they are seeing more than one consultant or care provider; this raised queries about why IT does not enable a holistic recording of a patient’s care. The NHS has worked in silos, hence, services are not joined-up; an issue that BCT is attempting to redress but seems some way off filtering through to patient experience.

PARTICIPANT 31: Does it not come up on their computer screen, because every time you go, they say, “What’s the matter?”, and I’m thinking, well look at your damn computer. ...They don’t seem to know and you’ve got to explain it. I think, well why am I explaining when it should be there?

PARTICIPANT 6: You walk in, they’ve got all your notes in front of them and then they ask you, when was the last time you had this test, when was the last time – as you say, we don’t have long in that appointment, and we’re recounting what they should already know.

PARTICIPANT 1: I think one of the other things is, because when you go to see your GP, or possibly when you go to a Specialist clinic, it’s very rarely that they have your medical history... That’s fine if you’re quite young with it, but if you are an older person, you don’t -- you’re stressed and you possibly don’t think of [aspects of your medical history].

PARTICIPANT 24: You have to explain everything to each person that you see. You have to go through it over and over and over again. If they read about you before you got to the appointment, you wouldn’t have to keep doing it.

PARTICIPANT 6: Once you’ve got complex health needs, you need to see the same person, don’t you? Or you’ve got to go through the whole scenario with every doctor. PARTICIPANT 3: It’s the time on it as well, I like to see a doctor who listens to me, so that I could get all of it out.

A single point of contact, and access to medical records, were seen by many focus group participants as key to managing complex and long-term conditions such as respiratory problems. Across the focus groups, participants showed an awareness that changes were taking place in Morecambe Bay to improve the situation, but the perception was that this was inconsistent:

PARTICIPANT 1: Now, with this Better Care Together computer system, let’s face it, everything should be at the touch of a button.

PARTICIPANT 33: I think people who’ve got a condition like ours should have an allocated Doctor and see the same Doctor all the time. I know it’s not going to happen but...

PARTICIPANT 1: They should have and be able to access our complete medical record, to be able to see what our complete medical history is. PARTICIPANT 2: That’s what they’re working towards. And it is like that sometimes but not always.

Likewise, participants across the focus groups expressed an enthusiasm for different services speaking to each other more, but did not report visible changes:

PARTICIPANT 22: They don’t communicate with each other at all. At all.

PARTICIPANT 14: They don’t seem to have any information about your child and if they communicated with each other, they would know what you were going in for. You have to go to the doctors and then you get sent to hospital and you just have to explain it over and over again to five or six different people. ...By the time you’ve explained it five or six times, you could have gone in straight away rather than waiting and explaining to someone else.

Much of the concerns around the continuity of care regarded communication, both within primary care and between primary and acute care:

PARTICIPANT 17: I’ve just had a medical procedure done, literally within the past few weeks. The hospital knew this appointment was coming up. My GP knew the hospital appointment was coming up, I knew the hospital appointment – I had made everybody aware of certain things that are in my background that are very valid and relevant to this appointment, that were very relevant. Yet, when I arrived at the appointment, the people that needed to know that information did not know that information. I had to tell them it there, face to face, again. It was embarrassing and I felt uncomfortable, I felt upset.

Specific Roles and Gaps in Services

While patient groups discussed more ‘traditional’ roles of health delivery – surgeons, GPs, and so on – a number of discussions focused on the roles which sat at intermediate points between the community and the hospital. These did not map directly on to the pathways that this evaluation had examined (e.g. care coordinators, community physios), but a role which was recurrently highlighted positively was the pharmacist:

PARTICIPANT 18: I do think that prescriptions have improved though. The fact that it’s always there at the chemist when you want it. You don’t have to really do a great deal. You don’t have to see the paper version anymore, do you?

The participants reported success with using a pharmacist who could assess their needs and give advice and, in some cases, prescribe medication for them. There also seemed to be a sense of empowerment attached to this, in that the individual was able to access expert care themselves without going through the GP. The pharmacist can also take an overview of a patient’s medicine use and flag-up interactions between prescribed drugs; there were suggestions that GPs did not always spot this risk. Those with co-morbidities and polypharmacy usage can benefit from a review of their medicines and any drug interactions that could be harmful. This would ensure people gain maximum benefit with minimal harm and waste.³⁹

Other roles were discussed less positively, with concerns around empathy, expertise and communication raised around non-clinical roles:

PARTICIPANT 3: I object to the receptionist asking you what the problem is... Not in a public area. Everyone is in the public area; everyone can hear the conversations. PARTICIPANT 7: I’m not happy to discuss my complications. PARTICIPANT 3: She wouldn’t know what to say as a reply anyway.’

PARTICIPANT 5: They ask too many questions.

PARTICIPANT 1: [the receptionist phoned regarding concerns over the participant’s son having a high incidence of injuries due to playing sports] I was thinking the receptionist shouldn’t be discussing this with me, on the phone. I was absolutely furious. I don’t really don’t think she should have had access to that information at all.

It is important to note that this theme is of interest, not because of the comments on receptionists per se, but rather how many of the tensions reported arose from communication issues, and a lack of explanation as to why or how interactions at earlier points may help to speed up appointments and treatments later on. While these responses allude to experiences of primary and acute care in general, there are implications for the ways in which BCT directs care to out of hospital areas, and how communication is handled in the process (particularly when citizens may be directed away from doctors). For example, in the shifting of clinics from the hospital to optometrists, a clinician raised the fact that a small number patients had raised natural concerns:

There's been a bit of uncertainty from some patients, saying how do they know the service is really as good. They're so used to having to come to the hospital and wonder, "Why can't I do that anymore? I trust them." (INT030)

Awareness of BCT

A small number of participants could explicitly identify BCT, and those that could spoke positively about it (although for different reasons – some linked it to the 'computer system', others to an event where over-60s were surveyed). It became apparent that participants were experiencing at least components of BCT, but without necessarily realising. In some cases, such as the Walney Cottage community centre, the group had begun locally, but had since been incorporated into BCT. As such, some participants could identify the changes, at least in their intention:

PARTICIPANT 3: It's easier access to other services and pointing you in the right direction.
PARTICIPANT 8: Like the doctors suggesting I came here [to the self-help group]?
INTERVIEWER: Yes.
PARTICIPANT 4: I think it's a very nice place to drop into, as well.
PARTICIPANT 8: You wouldn't want to take a tablet, but the meditation and things like that help, it does a similar sort of job, in a way.

Whereas others had experienced a move to out of hospital care, without identifying it as a systematic change:

PARTICIPANT 3: With Lancaster being my nearest hospital, I still thought I'd see a Consultant every now and again there, but no, I don't see any apart from my Doctor and COPD Nurse, unless obviously my chest is bad, I don't see anyone at Lancaster [Royal Lancaster Infirmary] now...
INTERVIEWER: Have any of you been given any sort of information sheets about new ways of working, or maybe seeing a Specialist Nurse instead of a Consultant? Have any of you been aware of anything like that? ALL: No.

As noted above in the discussion of community mobilisation, participants were enthusiastic about the community assets they were part of. Some identified this as a key change in the way they viewed their own health.

PARTICIPANT 7: If somebody had said to me this time last year, you'll be going to meditation, you're going to do this and you're going to do that, well I would just think I would be the last person in the world to say that I've sat there and done meditation, but I thoroughly enjoy it.
PARTICIPANT 6: It's lovely, isn't it? PARTICIPANT 7: It's fantastic, I love it. ...
PARTICIPANT 1: It's brought us all together. We've all got new friends and a nice little group.

However, there remained a large number who viewed the lessening of referrals to hospital, and the subsequent perception of a decline of input from consultants, as part of a broader frustration and, in some cases, despondency with healthcare services, whereby participants felt that they had to take the lead with their own, or their children's, healthcare. Indeed, one focus group was unanimous in agreeing that they had seen 'definite' changes in local health delivery recently, but identified this entirely in terms of the shutting down of a local service.

Improved patient education would help support the changes BCT is implementing (as has been noted by staff during interviews), for example: clearer explanations to patients about why speaking to a receptionist, or telephone triage with a healthcare professional, are efficient means of managing time and resources. Education would also help some patients understand why they are being referred to an exercise or other support group as a means to address isolation, lack of exercise, poor diet, low mood.

Patients attributed preventers to better care as the poor reputation of some hospitals (for example: 'they won't do it [operate on son]. I don't know whether that's because [Furness Hospital] were on special measures with kids and operations, but they won't do it' (Participant 1)); geographical isolation, and the problem of recruitment and attrition:

PARTICIPANT 6: But the hospital said to me that they're having a struggle getting the Specialists to actually come within borough, the people that they want.
PARTICIPANT 1: It's got such a bad reputation.
PARTICIPANT 6: In Barrow, because it hasn't got the theatre, it hasn't got all this. They want to be somewhere near a big city.
PARTICIPANT 4: Where it's modern.
PARTICIPANT 3: Newly qualified doctors, they have to offer them incentives to come here...
PARTICIPANT 8: We're having to go out of town for a lot of things now, because they haven't got anybody here. How do you make it more attractive to people?
PARTICIPANT 6: It might just be the geography of where Barrow is, as well.
PARTICIPANT 8: It is, yes. Everybody seems to say it's the back of beyond. It isn't now you've got the roads.



39 <https://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation>

9 Active Ingredients of a New Care Model

8.3 Discussion and Summary

As noted in Chapter 2, Chapter 7, and the quarterly reports to the NCMT, there have been changes to high-level metrics since the introduction of vanguard funding, particularly around non-elective bed-days and non-elective admissions.

However, it is not possible at the current stage to link these in a methodologically sound way to the changes which BCT has implemented. As such, these changes are correlative, but more work is needed to understand why these particular metrics are showing these patterns, in terms of mapping out the interventions which have contributed to it.

- This work would be chiefly around mapping outputs from specific interventions in a clear and systematic way at the planning stage of delivery. This would allow more localised measures (whether quantitative or qualitative) to scaffold up to the higher-level outcomes, and visible change to become apparent earlier within the NCM delivery.
- Many outcomes were reported anecdotally. However, while in some cases this is unavoidable (for example, ad hoc patient feedback on a service), in other cases there are more detailed and locally nuanced themes which could be introduced, which provides deliverers with an ongoing evaluation of their work, and commissioners a stronger sense of what is working for who. It may be the case that the use of anecdote is due to insufficient recording techniques for the kinds of changes taking place (for example, the lack of clear evaluation criteria for qualitative change).

The data suggests that localised successes are not currently being translated into whole-scale change. Given the variations in scale of many of the initiatives evaluated, and the low numbers of patients and citizens involved at this stage, this is perhaps not surprising.

It is important to note, though, that many of the incremental changes which have been identified by staff were also identified by patient groups as either showing effects (the sense that being sent to a self-help group was preferable to 'taking a tablet', for example), or being areas where they felt the quality of their care could be improved (for example, improved IT systems).

- This suggests that many of the qualitative themes around the changes the NCM has introduced have the potential to link up with patient expectations and improve the quality of care. These links must overcome the preventers currently in the delivery of the programme, however.

While some preventers of positive outcomes link back to contexts outside of BCT (for example, the general level of staff attrition, the perception of areas of Morecambe Bay as 'the back of beyond', or time pressures on clinicians), other preventers are linked to the structure of its delivery. Participants highlighted several reasons for stakeholders becoming disengaged in the process of delivering the NCM; many of which were linked to the lack of clarity around outcomes, and, related to this a lack of visible progress.

- This suggests that work on identifying more immediate and incremental outputs and outcomes of the NCM, coupled with a clear sense of how these relate to its larger-scale strategy, may well address many of the preventers which participants reported.
- It is also of note that the outcomes identified in the data reflect a number of outputs and outcomes on the 2016/17 BCT logic model. However, these are not systematic: the data collected and analysed does not identify a number of outputs and outcomes for Year 1-2, whereas some of the longer-term outcomes (3-5 years) are being mentioned. This suggests that the logic model is not featuring at the core of delivery.
- This may also be a significant factor for the number of participants who raised concerns about the structure, trajectory and overarching vision of the programme.

Evaluation Question:
What are the 'active ingredients' of a care model? Which aspects, if replicated elsewhere, can be expected to give similar results and what contextual factors are prerequisites for success?

9.1 Overview

The 'active ingredients' of an NCM are not necessarily identifiable as contexts, mechanisms or outcomes by themselves. Instead, they appear thematically at various points across the whole spectrum of delivery. To respond to this question, then, the evaluators re-analysed the data for the most recurrent themes which appeared throughout participant's responses, in order to identify the multi-faceted ways in which particular themes affected the success of the programme delivery.

9.2 Leadership

Leadership is a theme which has emerged consistently, both implicitly and explicitly, throughout the data. There is a clear link between the perceived successes of the programme to date, and the importance of leadership at every level. As with other themes, the concept of leadership in a NCM is not straightforward, but rather arises from a matrix of interrelating concerns around strategic goals, expectations of particular models of leadership, and moves towards collective leadership models.

Some of our ICCs have ... got a bit of a shared model of leadership and not everybody's looking to their door to tell them ... to take the direction of travel and say, "This is what I would like you to do." So, some of them are ... much more: "Any of us can have a good idea and any of us can lead on this." And others are a little bit more – using more traditional, kind of, hierarchy behaviours really. (INT058)

We've been very well supported in the Trust, in terms of accepting that we should be left to get on with it to a degree, and not be handcuffed by some of the traditional sort of things that might otherwise stop you. ... So we've been supported in taking things forward in the way that we can see working. (INT023)

In other cases, particularly clinical contexts, the importance of shared vision was paramount:

We've got a good core of strong, kind of clinical leaders within the system, who all have that shared understanding and shared vision and I think that's why we've been able to make the progress that we've made. (INT001)

On the one hand, then, the model of leadership which forms a positive active ingredient to the programme is iterative, and context-dependent; as one project manager summarises:

It's a balance between keeping the energy and enthusiasm, but actually orienting people towards the fact that there's something that we need that has to be delivered, really. (INT058)

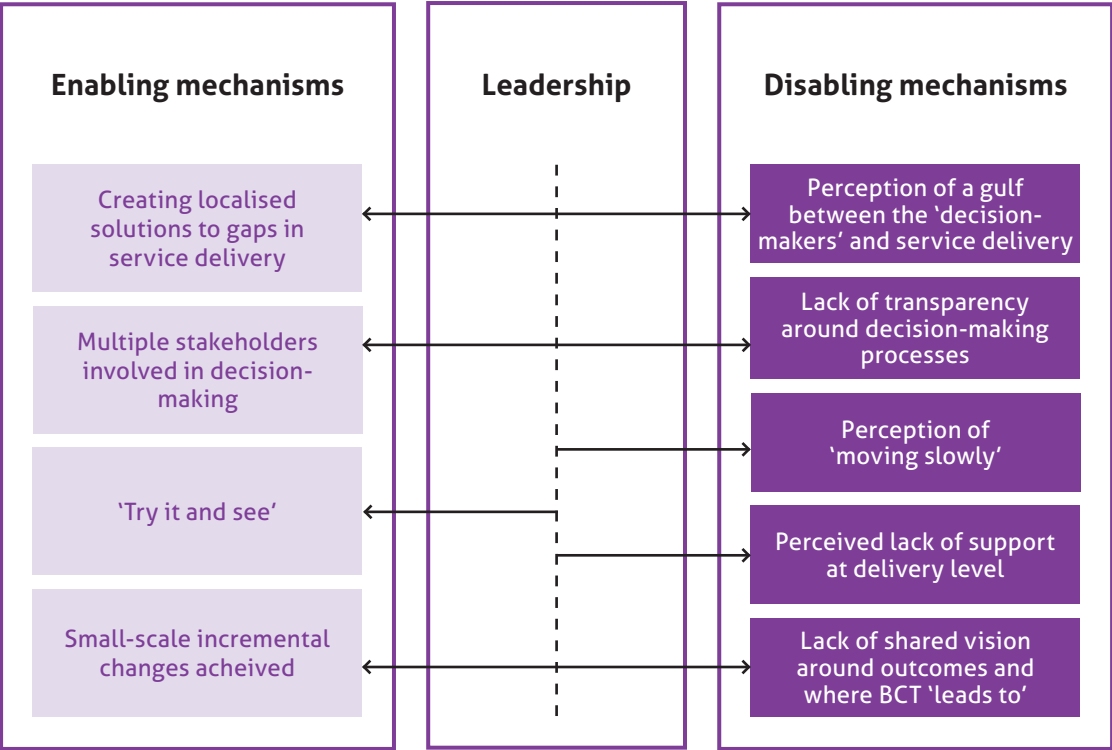
On the other hand, a common theme emerging across contexts suggests discrepancies between vision and strategy. For example, some participants from the Planned Care work-stream discussed how a concentration on hospital appointments is not consistent with the wider assumptions of the programme. Participants from Self-Care projects raised their views that BCT held too much of 'a medical model' which was incongruent with the social and holistic activities needed to achieve the programme's strategic aims: 'Most of the things to do that do not sit within the NHS.' (INT018)

A strong picture to emerge from participants’ accounts was the notion that a top-down model of leadership was inappropriate for the changes being attempted. The problem which was noted most frequently was that participants perceived that the structure of traditional models of leadership remained (for example, around the distribution of funding), but – perhaps in order to facilitate a more localised set of responses to population-based health issues – the ‘leader’ was absent or unidentifiable. We see this most commonly in participants reporting a lack of support (this was, in places, also due to staff attrition rather than style of leadership), and in the Out of Hospital activities such as ICC development in particular. Where leadership was praised, meanwhile, it reflected more of a collective leadership model. The exception was particular aspects of clinical leadership, which continued to reflect a more traditional model of leader.

One participant from primary care suggested the current BCT leadership model was too far removed from the challenges and opportunities ‘on the ground’ and operating within complex bureaucratic processes that hinder meaningful change:

I think what they need to do is to stop having so many new projects and people to manage projects. ... What we need is much less political interference in what needs to be done. (INT025)

The theme of leadership as an ‘active ingredient’ can be thematised in the following diagram, where the reported enabling aspects of leadership correspond with the reported disabling aspects:



► Figure 68 Leadership as an Active Ingredient

The themes have been presented in this way here to highlight three points around the notion of leadership as an active ingredient:

- 1) While some participants discussed models of leadership in more detail (e.g. personality types, specific leadership structures, etc.), this could be construed as comments on management, rather than leadership per se. Discussions on leadership in general focused more on the relationships rather than specific ‘types’.
- 2) While the enabling mechanisms of leadership identified by participants do present a certain ‘model’, what is notably absent on this list (and in the data overall) are strong examples of overarching system-wide leadership. But, as discussed in Chapter 6, the focus on incremental changes must be clearly related to a larger-scale model of change that such increments can demonstrate an effect on. Otherwise, the gap between localised delivery and strategic change will remain.
- 3) It is also notable that while some of the disabling mechanisms are structural (e.g. the perception that change takes too long, due to the complexity of the NHS, or the perception that support was not being provided from further up the organisational hierarchy), many of the themes of leadership revolve around issues of communication. Communication therefore forms the next active ingredient of the NCM.

9.3 Communication

The theme of communication emerged at every level of analysis, and good communication was a very clear ‘active ingredient’ for the delivery of the NCM. When we draw together all of the themes around communication from the interview data, it becomes clear that participants’ use of the term ‘communication’ is broad, and not limited to, say, a specific communication strategy in the sense of publicity campaigns. Rather, communication is a multi-dimensional ingredient. As such, it is intrinsically connected to other aspects of the programme: in particular, leadership and the importance of relational working. As an active ingredient, the quality of communication will produce different effects depending on where it sits in relation to these other key themes.

To illustrate the ways in which different aspects of communication have been identified as important to the success of BCT, we have modified from Shortell et al.’s work⁴⁰ on dimensions needed to achieve clinical quality improvement, and used the thematic analysis of the previous chapters to construct a matrix of the different aspects of communication. The table shows the four key forms of communication which emerged from the data, arranged from strategic to delivery level. Based on our analysis of the data, we hypothesise the likely results should one aspect of communication be under-developed in the delivery of the programme.

⁴⁰ Shortell SM, Bennett CL & Byck GR. Assessing the impact of continuous quality improvement on clinical practice: what it will take to accelerate progress. The Milbank Quarterly 1998; 76: 4, pp.593-624. The table is reproduced in Appendix Five, Evaluating Clinical Quality Improvement.

Leadership				Relationships				Result	
Clarity of strategy and direction	x	Multi-directional feedback loops to inform decision-making	x	Localised conversations between staff and organisations	x	Communication with patients and public	=		
0		1		1		1	=	Lack of direction, discussion without action, increased frustration and anxiety	Leadership
1		0		1		1	=	Disconnection between high level strategy and ground-level work	
1		1		0		1	=	Silo working, frustration over resource distribution	Relationships
1		1		1		0	=	Despondency over service delivery. Misinterpretation of integrated care	
1		1		1		1	=	System-wide delivery informed by localised integrated working	
0 = absent; 1 = fully present									

► Table 26 Aspects of Communication in an NCM

At the strategic end of communication, a strong view to emerge from interviews was that communication meant the flow of information from the strategic level to the delivery level:

If you're lower in the hierarchy, you get drip-fed bits and you might think, "It sounds okay, but what am I not hearing?" ... I think staff do worry about what they don't know. "I'm being told this, but what are they not telling me?" There's an element of distrust in the higher levels. (INT053)

Trying to talk to 1400 staff, or communicate with 1400 staff, is really difficult. You will get some that are highly engaged and some that are so far off the spectrum that when you ask them what BCT is they'll say, "I don't know". (INT061)

I think some of the anxiety has come around when people have been through changes and pilots before, and they haven't necessarily had all the communication, or something has worked and then it's been stopped because of various things. (INT005)

Enabling mechanisms around the theme of communication, meanwhile, allowed staff to understand the 'bigger picture', and their own roles in trying new approaches to delivery, and to situate individual's practice concretely. Likewise, communication between health services and the public also focused on raising awareness of an individual's needs and situating this in terms of the options available to them. Clear, accessible and transparent communication – 'having that open and honest communication to be available to patients, staff and clinicians' (INT005) – reduces anxiety about the envisaged changes and stimulates engagement with wider vision and strategy. For patients who might receive several visits in a day from health professionals, the NCM provides an opportunity for the same information to be collected in one visit, on the condition that communication is robust.

Alongside this, though, was an emphasis on the importance of localised 'conversations' (whether formal, through MDTs, or more informal). In this sense, physical aspects of communication have emerged as important: 'being down the corridor' from colleagues, or simply ensuring there are enough car-parking spaces to enable meetings, for example. In this way, communication as an active ingredient also encompasses the ways in which IT systems and IG access can 'speak' to service deliverers, and how different stakeholders are related to each other through technological and structural means. While the availability of technology is key to the delivery of specific projects (such as telehealth), several prominent themes have emerged where technology informs the communication of care: for example, using improved data systems to communicate patient needs across services, or using IT to access the right kind of data to communicate the success of particular initiatives.

At the far end of the table lies communication with citizens and patients. In Chapters 6 and 8 the complications of co-production of care, engagement and education have been discussed. In the case of communicating with patients and citizens around the NCM itself, there was a view from both service deliverers and patient focus groups that expectations had to be managed carefully. This provided a context for some patient views on the changes taking place in the health system:

PARTICIPANT 26: Your expectations haven't changed though, have they? It's not what we expect, it's just what we get. It's just getting further away from it. PARTICIPANT 28: It just takes longer to get to it.

As one consultant described succinctly:

Medicine is basically about management and communication. If you try to reduce that to people you don't know, or whose communications are in a different language, or in a broken form of the language that the patient is communicating in, then it's far harder for that to be a really high quality exchange, and for the patient to end up with good care, and to feel engaged with their care. (INT024)

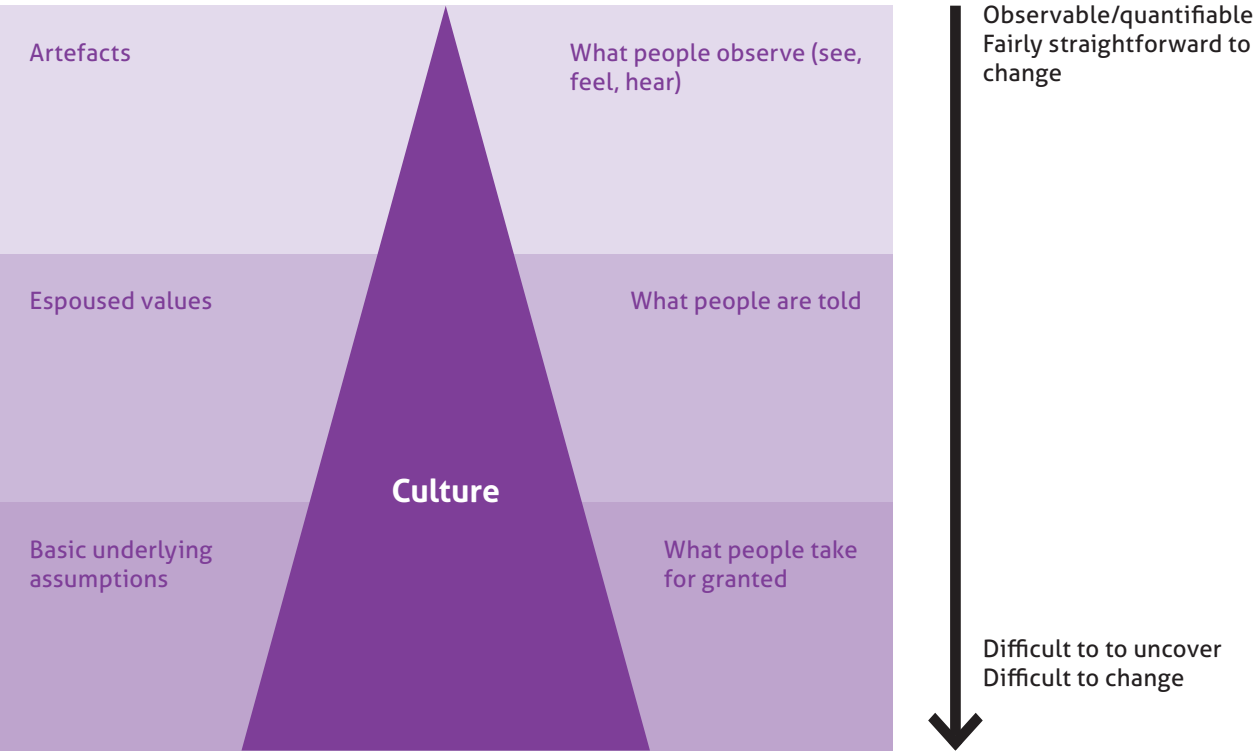
Whereas, when asked if people felt 'kept in the loop about changes or developments in your care' (or the care of your child), all focus groups to date responded 'No.' As a result, as Chapter 8 detailed, a number of the moves towards out of hospital care risked being misinterpreted as negative consequences of other changes within the health system.

The hypotheses within Table 25 suggest that some aspects of communication are embedded within aspects of leadership, whilst others are embedded within relationships, engagement and co-production. The former involves structural and strategic aspects, whereas the latter is often done without formal structures in place; but in areas where relationships were historically distant, or difficult to articulate, there was often anxiety. In short: while communication is an active ingredient of the NCM, it should not be thought of as separate from these other aspects.

9.4 Cultural Change

The communication work needed to deliver the NCM was often rooted in attempts to change the culture of health delivery in the longer term. Cultural change figured as an important aspect of BCT throughout the data, and for many participants formed the ultimate long-term goal of the programme.

In order to analyse how culture formed an active ingredient in the delivery of the NCM, we utilised Schein’s model of organisational culture. Schein’s model proposes that culture can be organised into three levels, which Schein labels ‘artefacts’, ‘espoused values’ and ‘basic underlying assumptions.’ Artefacts refer to the visible signs of culture – tangible, observable and quantifiable ‘things’ which demonstrate a particular culture is at work. Espoused values refer to the justifications for those ‘things’; the reasoning behind why a culture works in the way that it does. Finally, basic underlying assumptions refer to the unspoken rules and embedded beliefs which are often taken for granted, and rarely made ‘visible’, which form the deepest level of people’s beliefs and behaviours within a cultural setting.



► Figure 69 Schein’s Model of Organisational Culture

We used this to re-assess the qualitative data discussing cultural change, in order to identify where the basic themes could be placed on this model. Interpreting themes of cultural change through the lens of Schein’s scale raised some interesting and perhaps unexpected results.

Schein’s expectation was that cultural change in and across organisations occurs at a strategic level most easily, and takes longer to embed itself at the level of underlying assumptions. Conversely, culture change can emerge if there is a sea change in basic assumptions which causes the values and artefacts of an organisation to be re-thought.

Current BCT delivery, however, is very strong on the espoused values behind cultural change. According to Schein, this is not the visible message of change, but rather the justification or rationality behind it. In this sense, the principles of self-care, improving efficiencies, addressing gaps in local health provision and the long-term possibilities of a shift in health to out of hospital care, are common throughout the data.

But as noted in Chapter 6 and Chapter 8, there is currently a noticeable lack of artefacts which would qualify or quantify these, though. As one participant summarised in June 2017:

I think it's something that if people know what it's about, they understand the rationale behind it, but if you ask somebody whether they can see something tangible, I think people would struggle to answer the question. (INT037)

Throughout the data collection, and during the evaluation workshops, many participants questioned the visibility of BCT, both in terms of how and where it was recognised across Morecambe Bay (in terms of documentation, distribution of information, identification of individuals involved and so on), and the visibility of the message it was giving (i.e. what BCT actually was; see Chapter 6, Section 6.4).

Why was this the case? In some senses, this problem was anticipated in a 2013 survey of staff and public views on potential new ways of ‘joining up’ care in Morecambe Bay, where the ‘Overall response to most of the out of hospital scenarios and principles was “good words, but can we deliver this?”’ The report summarised:

*Most principles and concepts behind some scenarios are appealing and hard to argue against in principle;
But general scepticism and some strong concerns around delivery, given views of what might be required and how this matches up to the current situation and previous experience;
Many tangible factors were felt to be problematic or unaccounted for in the scenario/
principle descriptions.⁴¹*

Within the current evaluation project, there emerged from the data a number of themes which could be identified as preventing the translation of values into artefacts. Typically, these were identified in the context of participants delivering localised solutions which were not translated into longer-term cultural changes, for example:

- a perceived lack of support from middle management;
- a lack of multi-directional communication;
- silo working related to commissioning processes, IG and IT.

If this explains some of the problems with translating the espoused values of BCT into artefacts, a further recurring theme throughout the data was that the work of BCT – and the ICCs in particular – was around ‘changing mind-sets’, which suggests that direct attention is being paid to the third level of Schein’s model, basic underlying assumptions.

41 Better Care Together Engagement report (2013)
<http://www.bettercaretogether.co.uk/uploads/files/Engagement%20to%20date%20March%202017%20v0.01.pdf>

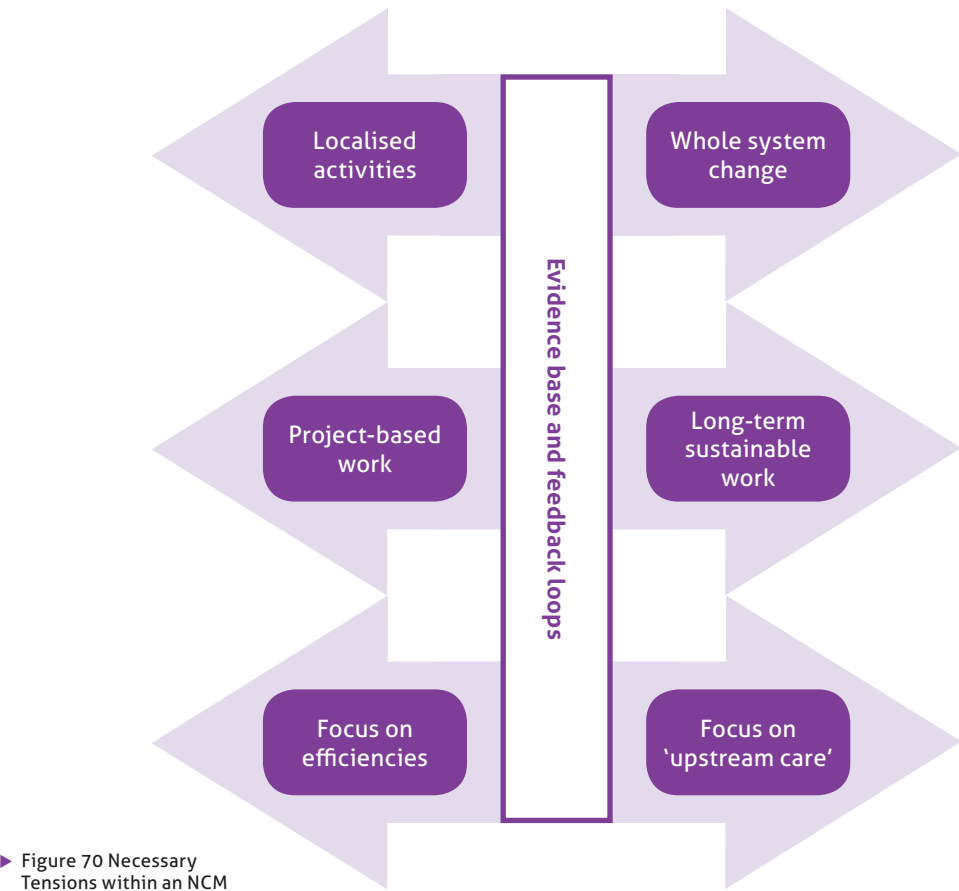
It is perhaps not surprising that this work is not always accompanied by methods of capturing or representing such changes; such methods are, as Schein’s model notes, very difficult to do. However, while a number of participants spoke positively of the ways that underlying assumptions are changing, there remain a number of different perspectives underlying the delivery of the NCM which appear to sit in tension with one another. For example:

- whether the NCM aims for an informed public or an empowered public, and what the possible differences between the two are;
- whether the NCM should be clinically-led, project-led or community-based;
- who holds ultimate responsibility for change.

This can be explored further through a more detailed analysis of integrated working (e.g. Multi-Disciplinary Teams), and in particular how shared and conflicting assumptions are negotiated within integrated pathways. The 2017/8 evaluation will focus on this as part of its work.

9.5 Necessary Tensions to Negotiate

A final ingredient regards the key tensions which are, in many senses, necessary to the kind of changes which both BCT, and the Five Year Forward View, entail. Throughout the delivery of the vanguard, tensions emerged at both practical and conceptual level, chiefly surrounding the scaling up of the changes being delivered. In the figure below, they are presented in terms of apparently contradictory themes which sit at either end of a continuum.



► Figure 70 Necessary Tensions within an NCM

Many of the concerns raised about the sustainability of the programme – in terms of whether funding would continue, whether staff would be retained, and whether long-term cultural change was achievable – were rooted in the apparent irreconcilability of these tensions. Delivering long-term sustainable work will, for example, always suffer frustrations from being based around smaller project-based initiatives, which are time- and resource-limited.

At the same time, data also suggests that these tensions need to be negotiated – even if they cannot be fully resolved – in order to accelerate the delivery of the NCM. The question this raises, then, is what the 'gap' is which sits in between the two ends of each continuum, and prevents themes from joining together.

While participants described a number of obstacles to achieving change (lack of time, complexity of IG and IT, and so on; as discussed earlier in this report), an analysis of how participants discussed these particular tensions suggests that the key gaps preventing are evidence base and multi-directional feedback loops in between localised practice and strategic decision-making. The lack of consistent data across the range of projects which form part of BCT tended to be perceived by participants as exacerbating the lack of a clear vision of the 'endpoint', or future of the NCM. This was also reflected in workshop discussions (see Appendix Four). The Vanguard Value Proposition document for 2016/17 claimed that:

the objective of the Research and Evaluation work is to ensure that evaluation becomes part of DNA and creates a virtuous learning cycle.⁴²

However, the sense that reporting measures were insufficient for capturing the work being done at localised levels was raised persistently in the data, and this was often connected to a perceived disparity between the long-term and short-term aims of the programme.

42 Better Care Together Vanguard Value Proposition, February 2016



10 Recommendations

While the NCM has been delivered across a large geographical area and involving a range of organisations, the findings of the twelve months of evaluations present a clear picture in terms of successes and obstacles. Based on our analysis of these findings, the evaluation concludes with the following recommendations:

10.1 Improve data reporting techniques and strategies

While there were a range of interventions either planned or in process 'on the ground', these often struggled to link to the larger-scale, strategic views of Better Care Together. This can be addressed in two ways: improving data reporting, and improving the links between incremental changes and longer-term strategy.

- The evaluation recommends that steps are taken to address the gaps in data reporting, in order for the NCM to demonstrate more robustly the effects of the changes it is delivering. This work would be chiefly around mapping outputs from specific interventions in a clear and systematic way at the planning stage of delivery. This would allow more nuanced, context-specific and localised measures (whether quantitative or qualitative) to scaffold up to the higher-level outcomes, and visible change to become apparent earlier within the NCM delivery. This includes:
Consistent and methodologically robust data collection around incremental change to target populations, with a more consistent approach to mapping inputs for interventions and activities, along with timescales (based on contextualised factors such as existing community assets and relationships), which can then be compared against outcomes.
Specific data to track for individual interventions on patient level, including inputs as well as output data which covers enough breadth to measure the impact of the intervention on a patient level.
- Evidence from wider literature suggests that the best measure of complex changes to models of care utilise a range of methods and data sources. Appendix Five below outlines some recommended approaches that BCT might consider for redressing the gaps in data that this evaluation has identified.

10.2 Improve strategies for demonstrating change

Alongside more nuanced and contextual data collection, the programme would benefit from having a clear evaluation strategy which covers all aspects of delivery, and from this use a set of evaluation criteria which enables different interventions to be assessed. There needs to be evaluation criteria to link up small-scale changes with large scale.

- A recurring theme for participants has been problems with identifying what 'Better Care Together' is, in terms of inclusion/exclusion criteria, measurable outcomes and 'what success looks like'. This needs to be addressed in order to avoid suspicions of the NCM being focused on financial efficiency over and above improved population health.
- A large number of participants indicated that it was 'too soon' for results to be showing from the BCT activities. This suggests that roadmaps were not sufficiently detailed to document incremental successes in the way that large-scale change requires.
- Ensuring that a theory of change, such as the BCT logic model, is aligned clearly to workstream reporting, will enable programme outcomes to be clearer, as well as routes to demonstrating effectiveness.
- It is important that the outcomes of the programme are clearly aligned to a range of evidence sources, and that outcomes are both specific and falsifiable, so that obstacles to achieving them can be identified more quickly. There has been a notable tendency for participants to avoid open discussions of unsuccessful interventions, non-developed projects and the severe delays that some workstreams have experienced. However, obstacles to change are as key as successes for understanding how interventions can be scaled up to the wider Bay area.

10.3 Consider the Role of Leadership, Communication and Cultural Change

There is a need for the programme to consider the roles of leadership, communication and cultural change in its delivery.

- In order to address the negative themes around these, it is recommended that the programme introduces more transparent 'feedback loops' within its structure. This would include feedback from organisations outside of the NHS, who are nevertheless key to the delivery of the NCM.
- Communication across organisations at ground level was reported as one of the key successes of the NCM. There may be some useful learning points and good practice from these successes which can support communication at strategic level.
- The public views solicited suggested that the aims of BCT were in keeping with public need, such as more personalised care. There are gaps, however, between service redesign and delivery and the understanding by the public of some of these changes. Some of this is due to the lack of clear indicators of incremental changes, educational attempts and general engagement with the public.



Appendix One: Semi-Structured Interview Schedule

1. How do you see [this activity/role] contributing to the New Care Model for primary andacute care?
- How does it fit with the Better Care Together programme?

• Do you think it is doing this successfully so far? Why/why not?
2. To what extent do you feel [this activity/role] has been implemented as planned, so far?
- What changes have been made along the way, if any? What caused these changesto happen? (Was this, for example, a contextual issue, or an issue with design?)

• In what ways have the changes been beneficial?
3. What do you think the key changes [this activity/role] is making so far are, and to who?
- Is it focusing on particular groups of patients (or staff/services)?

• How 'deep' is the change, in your view? (Does it involve, for example, a change insurface behaviour, or a change in deeper, more embedded assumptions?)

• Are their obstructions to change? (How 'deep' are these obstructions?)

• How do you think people feel about the changes being made? (e.g. Who is enthusiastic? Who is anxious?)
4. What difference do you think this is making to the experience of care in the local area?
- Is the more integrated approach enabling better quality of care? How? (e.g.Integrated Pathways)

• In what ways does [the activity/role] meet the needs of the local population?[which areas/ demographics is it aimed at, and is it reaching them?]

• Is it reducing/will it reduce admissions to hospital, in your view?
5. Have there been any unintended outcomes of the work on [this activity/role] so far?
6. What differences do you think this is making to the staff delivering care?
- For example, is there any upskilling or role redesign involved?

• Has communication between services improved?
7. Have you seen any change in use of resources so far from [this activity/role]?
- Is this a more effective use/less effective use?

• Are there any particular strains on resources?

Appendix Two: Survey Design

This short survey is about the introduction of integrated care communities (ICCs) into three areas across Morecambe Bay: Barrow Town, East and Bay.

The survey forms part of a larger evaluation of Better Care Together, which Bay Health & Care Partners have commissioned HASCE at the University of Cumbria to conduct.

The survey should not take more than ten minutes to answer, and your responses will be used, alongside data from other evaluation activities, to inform the future development of ICCs across Morecambe Bay.

Your survey responses will be anonymous and handled confidentially, and no individual will be identifiable from any outputs. You do not have to answer any question that you do not want to, and you can end the survey at any time.

If you have any questions about the survey or the evaluation more generally, then please contact hasce@cumbria.ac.uk.

In which locality do you work?

- ☐

Barrow Town
- ☐

East
- ☐

Bay (Morecambe)

What is your job title?

To the nearest month, how long have you worked in this job?

To the nearest month, how long have you worked in this locality?

On a scale of 1-5, where 1 is "not at all" and 5 is "very much", how **engaged** do you feel with your local Integrated Care Community (ICC)?

☐ 1 Not at all

☐ 2

☐ 3

☐ 4

☐ 5 Very much

Comments (e.g. why/why not?):

On a scale of 1-5, how much impact do you think the ICC has had, to date, on your day-to-day work?

☐ 1 None

☐ 2

☐ 3

☐ 4

☐ 5 A lot

Comments (e.g. examples of impact):

On a scale of 1-5, how much impact has the ICC had on your delivery of services?

☐ 1 None

☐ 2

☐ 3

☐ 4

☐ 5 A lot

What, in your view, are the most important changes that the ICC has brought about in terms of the way you work?

On a scale of 1-5, in your view how much has the ICC changed the experience of the people using your services?

☐ 1 None

☐ 2

☐ 3

☐ 4

☐ 5 A lot

What, in your view, are the most important changes that the ICC has brought about so far for people using your services?

How well do you feel that understand what the aims of your local Integrated Care Community are?

- ☐ Not at all
- ☐ Somewhat
- ☐ Very well

If you chose "Very Well", what do you understand the main aims to be?

If you chose "Not at all" or "Somewhat", what are your main reasons for this response?

How well do you understand the aims of Better Care Together?

- ☐ Not at all
- ☐ Somewhat
- ☐ Very well

If you chose "Very Well": what do you understand the main aims to be?

If you chose "Somewhat" or "Not at all": what are the main reasons for your response?
Optional

Do you feel that you understand your role/responsibilities within the ICC?

- ☐ Not at all
- ☐ Somewhat
- ☐ Very well

If you chose "Very Well": what, if anything, could enable you to fulfil your role/responsibilities better?

If you chose "Somewhat" or "Not at all": what, if anything, could enable you to understand your role/responsibilities better? *Optional*

Appendix Three: Focus Group Schedule

About your involvement with the health system

Could you describe some of the things that are important to you when you are seeking healthcare support?

- Kindness/politeness of staff?
- Time spent waiting at & for an appointment?
- Location of care e.g. at home, hospital? Journey time?
- Staff giving you time to ask questions?
- Additional needs (e.g. social) being taken into consideration?

About changes in the health system

Have you noticed any changes to the way care is provided by the NHS in your area recently/over the last year or so?

- Has this made any difference to your experience of care?
- How has this affected your specific needs [i.e. long-term conditions]
- Have the changes been positive or negative? If positive, what, and if not, what was missing?

Would you say that your expectations for your own care have changed over the last year or so, in terms of the services that are available to you?

- In what way?
- What caused this change?

Are you aware of Better Care Together?

- Do you have any experience of this new way of working?
- What are your thoughts on BCT as you understand it?
- E.g. Seeing a specialist nurse/physio etc. rather than a consultant?
- E.g. spending less time in hospital

About co-design and communications

How much do you feel involved in your own care?

- Are you listened to by your care providers?
- Do you attend a support group?
- Online or telephone support?

What are your experiences of communicating with healthcare providers?

- Could you describe a good experience of communicating with a provider?
- What could improve communication?
- Are you kept 'in the loop' about changes or developments in your care?

What would you do if you feel your needs are not being met?

- Make a complaint?
- Try a different path for care support?
- Ask for advice on what to do?

About a joined-up service

In your experience, do the different health deliverers you are involved with communicate well with each other (e.g. about your care)?

- Do you feel information is passed well between e.g. GP and hospital?

Do you feel that you have a similar standard of care across different providers?

- Hospital, primary care, third sector (if relevant)

Appendix Four: World Café Discussion Summaries

Discussion Question: Does/has cultural change occur/occurred from the ground up, or the top down?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
Cascading from shared learning Shifts in individual clinician's approaches. Areas where barriers are broken down eg. Hubs; ICCs etc. High level leaders are engaged – cultural change is happening at this level... what about everybody else? Limited eg optometrists now working alongside and supporting ophthalmology. Better information and education available for GP practices. Local solutions and fixes to get things done.	Common purpose (across organisations) ... what would it be? Understanding what the various groups in an area do (eg groups run by Age UK Barrow/Ulverston). Changing workforce and patients, not those at the top. For the patient – single point of contact. Stakeholder buy-in, I.T. is going to enable new working. Empowering patients to navigate a complex world. People at the top must set the example of what they want. Triage nurse in every GP surgery, which would direct patient in right avenue. Coding of records has enabled identification of groups of patients eg condition registers. Honest communications to ensure there is a connect between top and bottom.	Information doesn't always flow down to the ground level. Busy/time demands on staff to attend meetings that involve other groups – national shortage of nurses. If people feel 'done to', Or if people <u>are</u> 'done to' eg diagnostic practices. Awareness of full spread that information needs to have. Lots of people talking does not necessarily mean joined up delivery. Expecting a huge workforce to change is very hard. People need to hear about BCT... through advertising? Publicity? The way GPs are funded does not encourage them to engage with BCT. Contracting and funding streams need thinking about. Staff worth not reflected in their pay. Fragmentation of systems across services. Consultants in hospitals need to change, protect the system they create. Patients not good at saying what they want. Contradiction with the top – not always in agreement. Communication is not good between various health bodies, it is there, but information can be difficult to find. No joined up thinking about disseminating knowledge about BCT to health staff. Need to acknowledge those who don't have computers, have verbal disability. Monies not available for more care in community. Those in the middle – a disconnect here. Need cultural change to be embedded and sustainable. Citizens don't have a full understanding of how the health & care system is set up/works and the difficulties faced.	Think about communication routes eg Unions/RCN etc. Structure may come before cultural change. Moving beyond individual 'culture' and to a broader health economy. Need to hear about good practice. Engage with the community – they are the 'keepers of the culture'. New financial, contractual reorganising. Use local media as a means of promoting BCT. Better PR is needed, needs to be much more public. Need honesty at the top. Need a clear message, consistency and not just focused on money/finances/politics – need to communicate clear rationale as to the 'why' behind thought processes.
Question for the Panel: - How do we get effective leadership that reaches staff and patients? - Where is the money coming from that would allow more community services in order to free up beds in the acute trusts? - What is the definition of top, bottom, middle – who are in these groups? There are different perspectives on this. – How do we improve communications between the tiers; in a multidirectional way?			

Discussion Question: Are patient and public views of health services in Morecambe Bay changing? NB one group suggested this ought to be changes in BCT – their comments are in <i>italics</i>			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
When there is more 'community'	Longer term education	A class thing (upper, middle, lower) – general expectations e.g. seeing a specific GP	Smaller things e.g. presence of pharmacist
Accelerated ICC i.e. embedded within existing communities	15min nurse sessions (at Dutton Valley – small)	Unwillingness to make decision – Too much choice?	Improved access
BCT encouraging other services to share info	Feedback source	Perception of 'having to pay' id not referred	Awareness of size/scope of e.g. ICC
Good learning around ?/dementia	Volunteer ??	GP conglomeration/bigger groups – sense of 'abandonment'	Awareness of difference of 'good health' perception e.g. social capital
Representation of user needs in care planning	More 'touchy feely' – a genuine desire for <i>many</i> patients	Small practices need a voice (so that patients can be represented)	Engagement through the GP is the norm
So change is incremental	Not being 'precious' about areas	Mergers/structures that are less clear e.g. city centres	Improved sharing of vulnerable people's needs
Limited and very fragmented	Quality improvement <i>not</i> about money	Dissemination of info to patients is lacking – not evident	Integration of IT services throughout
Lancaster hospital seen as improving	Shared IT full IT compatibility	V large GP surgeries are impersonal not necessarily providing patient led services	Improved Facebook and twitter usage
Ophthalmology services from integrated care seeing the ophthalmologists in shops has reduced the number of hospital ????? required	Educating in early years	Vulnerable people are at high risk	Need to sell our NHS better and our services available
National media	Proactive in sharing knowledge	Historical issue of FGH maternity services has not been resolved in the public perception	Engage in communities and keep them informed
Patient engagement	Keeping momentum going	Patients themselves trying to engage not everybody will get on board	Invest money in promoting and education patients of downfalls
Better communication at all levels	Gateway Hub 36 charities engaging together (Kendal?)	Not much communication at all levels	? clarity on patient views? On patient outcomes? - What is baseline?
Education once experience disease/condition – started	Invest in health promotion/prevention	Patient expectations	Selling the success of the access to services
Friends and family – audit/evaluation	Actual "real" stories @pt experience	Inclusion of staff (employees)	Clinical governance/IT data protection to allow shared notes
Service transformation allows access to service users/patients	ICC – include in holistic evaluation	Language used	Look at the patient outcomes you seek – bigger picture
Care navigators – new role – projects – prevention of social isolation	Inpatient story to be told once – SPA (single point assessment)	Understanding of what is out there	
Specific assessments – include eye test – prevent falls		Culture: <ul style="list-style-type: none">- age population- Entitled to it – NI paid- Young- Instant won't wait?	
		Lack of shared ownership	
		Integrated records (IT)	
		Different programmes/systems	
Question for the Panel? People accept there is a problem but how do we change behaviour? How do we address the culture of expectation? - Are service changes being made to meet the patient/public's needs?			

Discussion Question: What are the shifts in perceptions of health towards a broader understanding of wellbeing? What is left to be done?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
Patients talking more openly about health issues	Stakeholder engagement including public health to present 'united' approaches – stronger 'buy-in' by partners	Ability of some ICCs to progress has been limited/taken longer to become high performing – not consistent across all	Integrated IT
Strength of relationships between commissioners and providers; people more empowered are likely to take things forwards pro-actively	Personalities/system leadership	Knowing who to involve and engage as systems and people continue to evolve – helps to come together around a theme e.g. mental health; wider issues such as loneliness and isolation	Signing up to sharing agreements
	Systems and processes e.g. chronic disease registers	Information governance management	Clarity on who to ask
	People feel more empowered/or feel the need to take responsibility		More engagement with service users
	Engagement		
	Key structure in place- Things put in place matching structure – 1 Health and Wellbeing worker in each of the 3 ICCs		
	Use of language, embracing wellbeing as well as health		
Not related to BCT but quality to patients is key, and striving to maintain staff morale	Personal support to staff and patients	When potential outcome isn't explained properly	Clarity Evidence
	A personal touch – follow up on communication	Not 'mucking in' from the top – lead by example	
	Nurturing staff		
Conversations are happening between services and communities and between services	Necessity	Lack of money creates challenge to approach things in more novel ways	Engaging businesses/private sector
More awareness of health and choices	Being invited	Targeting deprived groups	Their responsibilities as employers
Dementia Friends	Alignment of services		Upskilling community members
Health Champions	Dementia Friends – others in community helping and identifying problems		

Discussion Question: What are the shifts in perceptions of health towards a broader understanding of wellbeing? What is left to be done?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
A move towards a whole person perspective (holistic approach), rather than looking solely at conditions	Care plans	IT system	Supporting 3 rd sector agencies to support people with wellbeing
Pro-activity	Multi-agency groups	Resources for investing in wellbeing. Most invested in 'traditional' health conditions	Educative communication
	Talking to each other	Lack of understanding/ perceived lack of value of third sector	Funding small 3 rd sector agencies – or making them more sustainable – through subsidies
	People/roles e.g. matrons for BCT	Funding too restrictive / or lack of	Evidence accumulated needs a platform to demonstrate their value – how to they 'publish' evidence of their value?
	Being open to change, ability/receptiveness to learn	Lack of perceived value	Representatives from each agency on steering groups
		Wellbeing has been stigmatised	
Question for the Panel? Where are we with patients booking online across the Bay?			

Discussion Question: Moving from silos and territorialism: has aspiration become reality?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
Millom – GP practice and MBHT partnership Recruitment of GP- paed's & GP	Common issue failing community <ul style="list-style-type: none">Crisis with system impactPopulation gets motivated<ul style="list-style-type: none">Mobilisation Leadership – permission Seeing interconnectedness / Interdependency of series Joint working/collaboration Challenging certain behaviours	Policy and procedures Individual perspective – service v system outcome Service targets v outcome targets Conflicting targets <ul style="list-style-type: none">Organisational inspection v system / geography inspection	Giving permission to question/take risks/be innovative
Pockets where organisation working together 'grown up conversations' 2x CCGs aligning with Morecambe Bay footprint Moves to create a new integrated community group (UHMB & CPFT)	Partnerships = way forward honouring 'specialist' skills	Value of 3 rd sector is immense but not recognised by NHS eg Kendal Gateway (Animation Day Barrow), where networking can happen Hard to access small cultural groups – the people are not embedded to allow the initial conversations/assessments to be done	Blockers are in the middle of the structure – top down and bottom up are 'hearts in it' to make change

Discussion Question: Moving from silos and territorialism: has aspiration become reality?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
42 charities (S. Cumbria) part of Gateway Collaborative – working with NHS/BCT Multi agency referral system (refer to other agencies)	Partnerships Agreements	Financial focus Perseverance Multi-agency / professional development. Learning/Education levy should be available to third sector (LETB) Governance/formality	Focus on patient outcomes (outcome focussed) Enable LETB funding for 3 rd sector professionals
Opportunities to engage BCT Devt. Groups (diverse) £6000 incentives Closer working between professional groups eg optometry and ophthalmology Public engagement in ICCS has developed <ul style="list-style-type: none">Debates with local population re self-care and prevention	Persistence Evidence that it works Making the case	Professional barriers Perverse incentives – resources for services Training/education Patient/public expectations	Adopting spread in other disciplines Changing the incentive system. System-based rather than service-based Move away from professional targets Geographical accountability not organisational accountability Engage with public on prevention and self-care Training/CPD of professionals and patients Overcome organisational barriers
Question for the Panel? How do we delegate authority to allow individuals to operate across the system? Is person-centred care an assumption or reality in the system? How much opportunity is there for people in the NHS to take stock of where we have got to and from this identify areas where we need/can move on? How do we break the continued focus on finance? With the current financial crisis, how do we retain a partnership approach in BCT?			

Discussion Question: Utilising previously untapped resources, and upskilling staff: how does this inform and create changes in culture?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
Upskilling staff to look at the whole person care and undertake different skills to prevent referrals Reducing hand offs working differently holistic assessment One assessment ICCs are doing well Using schools to host isolated people at afternoon tea Upskilling of staff – physio and pharmacy Using high-street opticians to refer people to ophthalmology Sharing within staff groups e.g. care navigator Attempts to pull together organisations/services that wrap around the person Raising awareness of 3 rd sector/charities and using their services to support people BCT ophthalmology and MSK projects using skills of community practitioners not previously used who have already got the required high level skills	Utilising third sector to provide elements of care Directory of services Investment in staff Making time Communication – talking to patients Patient education – self-care self-management Shared decision making Demedicalisation of the model Re-educating people – guiding them away from A&E Using pharmacies Making people aware when and where to seek help Requires funding levels that support these services Untapped 3 rd sector organisations Sourcing university students to design social media Giving staff a time and space to share Tap into patient/carer and 3 rd sector resource for their experience, views, knowledge etc. Think about other (non-people) resources available e.g. space in buildings for people to meet Tap into knowledge from individuals within the community not just about services but what's going on in the community	Mutual respect with VCFS Locations Accessibility Knowing the ?list ? fit ? of services Are staff skilled enough to understand e.g. taking blood pressure? Do teams have capacity to meet needs e.g. paramedics giving antibiotics Fer of litigation Culture change amongst people regarding who to see, GP or Physio Rural area in Morecambe Bay do partner organisations have governance in place? Staff maybe unsure of small 3 rd sector groups do they have governance? How do we find untapped resources? Protectionism – silo working Evidencing/validating practices e.g. arts or 3 rd sector provision that could support the health system but there is no time to research/evidence effectiveness so it doesn't get commissioned Governance/bureaucracy – how can we simplify/scale levels of bureaucracy according to levels of funding Some high level skills not being used e.g. optometrists – not used as outside scope of initial services Not knowing what 'expertise' is available	Breaking down the barriers Social value Traditional Practice Reduce silo working upskilling staff to undertake one assessment meant rather than multiple assessments Walk-in centre? Social media are advertising NHS services in more built up areas Organisations who can fill the gap between the hospital and home The way 3 rd sector is resourced needs addressing Sharing skills and staff communicating well Across the NHS good practice isn't always shared Giving nurses time to share and communicate Engage more in informal 'conversations' develop relationships to utilise resources more effectively Encourage more 'social' interaction between GPs to spread knowledge Shared training system so NHS/social care business managers, project staff, bureaucratic staff run shared sessions to upskill/enable small businesses/small charities working in the health sector so that they can expand and deliver more services Offer space in community resources for other organisations to use e.g. Dutton Valley Volunteers
Question for the Panel? – How can staff be given time to share ideas and good practice? How do we re-educate the public to use the NHS? Social media maybe? Governance			

Discussion Question: Integrated Care: what changes have been made – or need to be made – to ensure care is integrated positively?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
Early Adopters eg Garstang, Carnforth Focussing effort on local needs/themes Registers e.g. frailty in Grange, where frailty is identified by GP, assessed in own home and referred to Age UK	Population centric approach enables integrated care to be appropriately commissioned and delivered Inclusion of other service providers e.g. policy, fire personnel, third sector Ability to enable peer group support Strong local leadership Engaged staff with local knowledge Good information for signposting and use of Care Navigators	Patchiness e.g. mental health particularly an issue; some good integration examples Funding limitations How to know who there is and who to go to – ongoing engagement and communication needed Flexible workforce who are not aligned to Acute/Community (mentally)	Strong champions needed for specific areas e.g. mental health, to make sure all issues are progressing in terms of integration Learn and share lessons from ‘small’ sites (don’t just wait for whole economies/large geographies) Demonstrate impact more broadly e.g. there will be mental health benefits to local interventions e.g. home visits, easy breathing classes but might not be captured so could appear that mental health is not being targeted/Improved
Primary care/acute care part of MDT to facilitate discharge Meetings in place to integrate with mental health Care plan/passport Pilot to integrate hospital discharge with social care	Telling your story once. Using some evidence Moving towards a 18-25 transition period (Mental Health) Communities working together to provide support/groups Whole person health Where appropriate, self refer	Information governance, shared records Transition from paediatric to adult care Recruitment Local communities unaware of care plans Geography Real issues for that locality Tendering services Brand – Age UK Working with other localities (GP)	Patient involvement in frailty Shared decision making Emergency plans of care Differences between Morecambe Bay and Cumbria Patient Information De-medicalise to the public, to get interventions in earlier Reaching hard to reach groups, e.g. carers

Discussion Question: Integrated Care: what changes have been made – or need to be made – to ensure care is integrated positively?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
Opportunity to bring agencies together	Communication and dissemination to inform patients/users/population to go to the right place (and appropriate time) to access what they need Including all sectors/service providers when developing care pathways Is there a shared database of all third sectors? If there is then who has it/how is it accessible?	View that third sector providers may be used as a cheaper option – dialogue around commissioning Knowledge/understanding of the whole sector by staff Funding disparities ‘Pateley’ relationships with social services and third sector Empowerment of individuals to self diagnose/access services appropriately	Depends on local structures. Needs stronger focus and leadership and structures e.g. involvement of a social worker within team in Blackpool Trust Communication e.g. about what BCT is/is going to be needs to be ongoing, not at the beginning of a ‘new’ initiative
Accountable care systems and strategic partnerships in place	Differentiated comms strategies Navigators – supported by effective IT systems Support for vulnerable people to access what is available to them especially where they have complex needs Data sharing/shared records access via IT, e.g. so an elderly person presenting at A&E can be appropriately discharged	BCT communication – not reaching individuals Engagement – difficulty identifying people who can enable cascade of information Assumptions that care is integrated/services aligned when reality is different – emphasis has been on getting systems/processes in place People losing track of who’s who – PCTs, CCGs etc How do people know who their care navigator is?	Review needed of comms strategies now BCT systems and processes are coming into place, so that examples of the real difference integrated care is making are shared with people at an individual level Some good case studies of involvement of local authorities/social care/social workers – this is not always evident
Question for the Panel? Increasing public awareness / share information of services How are GP practices themselves integrating with each other?			

Discussion Question: What are the keys to engaging stakeholders across Morecambe Bay in cultural change?			
Successes so far	Enablers for success	Obstacles to success	Suggestions for overcoming obstacles?
Inclusivity “Urgent GP access” Dutton Valley Medical Practice Reciprocal support Team work <u>everyone</u> matters Team building Patient led assessment of the care team/facilities Talking to each other <u>about</u> stakeholders but not e.g. Sue’s Mum Engagement work a noted success e.g. individual ICs but NB caveat	Effective communication i.e. radio, Facebook, social media Adverts on TV People are ‘citizens’ not ‘patients’ Community engagement Smaller charities/orgs should be stakeholders Engagement with carers Not confusing engagement and consultation Crisis point – things to learn?	Bad experiences People having not grown up with technology or do not <u>have</u> technology Someone too proud to ask someone to go in and see them Exclusion of team members Not enough investment in communication etc. Lack of recognition of 3 rd sector providers e.g. need for more inclusivity Perception of financial need Can feel a bit <u>centred</u>	Coffee mornings Pro-active phone calls Patients only calling a doctor if they think they need – linked to this can we look at all ways of communication to access <u>everybody</u> . (There is no I in team.) <u>Never</u> assume anything. Follow up important things in a timely fashion. The Hospice has set up e.g. a compassionate community So maybe need to rethink BCT from the bottom up Learning from the 3 rd sector Rethinking comms e.g. learning from other places
Linking up different groups e.g. people on the allotment list with people who want to garden The start of community conversations Links between NHS and local government re population health – strong and continuing to develop Good 3 rd (vol and community) sector engagement Knowledge of BCT as a point of contact and access for other stakeholders is positive	Enthusiastic communities (arrow to suggestions column) Communication Understanding Lose the silo thinking (collaboration) Marketing – engaging others Communication on different levels – IT, posters, events	Finance Geographical issues – especially difference local government i.e. Cumbria and Lancashire Organisational/professional/academic language obstacles between organisations and when engaging communities Silos, professional and organisational hierarchies Need to engage more with stakeholders Need to promote the integrated way of working across all stakeholders Parity of respect – inclusion in all activities	
Question for the Panel? How does BCT learn from the third sector meaningfully? How does BCT ensure a holistic view of the health economy e.g. how do these comms?? happen meaningfully? Is it about a) culture within the NHS, or b) culture across the health, care and 3 rd sectors or c) whole population? How do you keep the momentum and engagement going?			

Appendix Five: Evaluation Methods for Specific Gaps in BCT Data

Throughout the evaluation report, several areas have been raised as demonstrating gaps in data. These gaps were also reflected in the evaluation workshop discussions. While there is no single and definitive ‘answer’ for addressing these – every evaluation needs to be designed according to its context and purpose – the following methods were identified during the course of the evaluation as starting points for addressing the gaps in data. They are listed here in the spirit of dialogue with those delivering BCT, in order to identify ways in which the quality of evidence around the successes of and obstacles to the NCM may be enhanced.

Evaluating Collaboration

One theme which emerged was around how organisations could assess the success of collaboration, across sectors and geographies (e.g. primary and secondary care, voluntary sector). Evaluation literature tends to agree that there are key areas for achieving positive outcomes:

- Having a clear definition of success;
- Defining success in a way that needs and perspectives of stakeholders are recognised;
- Transparency of communication;
- Attention to collaboration operations (structures, procedures, metrics), and their relation to non-collaborative operations;
- An increased capacity for collaboration amongst stakeholders as a tangible outcome.

If this sounds straightforward, Norris-Tirrell nevertheless argues that ‘while an exponentially expanding set of researchers and practitioners conduct research, evaluations, and theory building reports, articles, and books on the topic of collaboration, the efficacy of the strategy remains murky.’ Perhaps this is in no small part due to the fact that ‘the success of collaboration depends on the situation, the actors, timing, and so on.’⁴³ For this reason, much of the current evaluation research is case-based, as this allows evaluators to describes and analyse a situated collaboration in order to draw lessons for the future. But these can be time-consuming and, given that a case study is always a sub-set of a broader system, requires careful thinking around which cases to use.⁴⁴

In contrast to the case based approach, other evaluators have used structured surveys to measure the effects of collaboration. For example, Marek et al. have developed a ‘Collaboration Assessment Tool’.⁴⁵ The survey questions embedded within this tool may be useful starting points for thinking through what kind of data would evidence successful working across organisations and sectors.

43 (Norris-Tirrell 2012, p.4)

44 <https://case.edu/affil/healthpromotion/ProgramEvaluation.pdf>

45 Marek, L., Brock, D-J., Svla, J. Evaluating Collaboration for Effectiveness: Conceptualization and Measurement. American Journal of Evaluation, Vol. 36(1), pp. 67-85 (2015)

Evaluating Engagement

One of the most widely-used models for evaluating public engagement has been created by Rowe and Frewer.⁴⁶ This approach essentially breaks the success of engagement into two aspects: how participants are involved in the construction of the engagement, and how fair they perceive it to be. Rowe and Frewer describe this as ‘process’ and ‘acceptance’ criteria:

Acceptance Criteria:

- Representativeness: public participants should comprise a broadly representative sample of the population of the affected public.
- Independence: the participation process should be conducted in an independent, unbiased way.
- Early Involvement: the public should be involved as early as possible in the process as soon as value judgments become salient.
- Influence: the output of the procedure should have a genuine impact on policy.
- Transparency: the process should be transparent so that the public can see what is going on and how decisions are being made.

Process Criteria:

- Resource Accessibility: public participants should have access to the appropriate resources to enable them to successfully fulfil their brief.
- Task Definition: the nature and scope of the participation task should be clearly defined.
- Structured Decision Making: the participation exercise should use/provide appropriate mechanisms for structuring and displaying the decision-making process. [NB. This is sometimes rendered ‘structured dialogue’ if decision-making is not considered viable]
- Cost Effectiveness: the procedure should in some sense be cost effective. [NB. More recent versions of this model remove cost-effectiveness, as it is argued that participants would not have this kind of knowledge]

By testing engagement around these headings, Rowe and Frewer have aimed to provide more ‘objective’ accounts of the success of engagement activities. However, they caution that engagement exercises have ‘been variously described as consensus conferences, deliberative conferences, citizen advisory committees, citizen advisory boards, focus groups, task forces, community groups, negotiated rulemaking task forces, community advisory forums, citizen initiatives, citizen juries, planning cells, citizen panels, public meetings, workshops, public hearings, and others.’⁴⁷ But each of these may involve a different definition of success. As such, attempting to use a universal category such as ‘effectiveness of public engagement’ has to be accompanied by a clear articulation of the time and space that engagement takes place within, so that success can be compared across them.

For example, in the second BCT workshop it was noted that attention needed to be paid to how, where and when questions are asked, and how this might implicitly ‘shape’ the responses received, as well as the conditions determining the ‘effectiveness’ of an engagement. Likewise, there was a discussion of how engagement in evaluation needed to show results – feeding back on a process needed to have a visible effect (whatever effect that might be) in order for it to be worthwhile; otherwise, participants may be less willing to engage at all. All of these will affect the success of an evaluation.

46 Rowe, G. and Frewer, L. Evaluating Public-Participation Exercises: A Research Agenda. Science, Technology, & Human Values, Vol. 29 No. 4, pp. 512-556 (2000)

47 Rowe, G. and Frewer, L. Evaluating Public-Participation Exercise, p.550

Evaluating Localised Metrics across Areas

One recurrent issue around ongoing evaluation was how to report on population-based and localised interventions, such as within ICCs, which would demonstrate success through nuanced or contextual changes that do not ‘travel’ well up to higher-level metrics.

The following chart is a ‘personalised advice template’ presented by the Nuffield Trust as part of their evaluation of the National Association of Primary Care’s ‘Primary Care Home’(PCH) programme. This was based on a dialogue between evaluator and programme to identify the different ways in which metrics could be identified to make the programme aims tangible.⁴⁸

Four aims for the PCH	Domains of measurement	Examples of ways to measure this
Improve whole-population health and wellbeing	Population health and wellbeing	Your current proposed measures: Additional measures you could use:
Improve quality and experience of care for patients	Patient outcomes (including clinical and process measures)	Your current proposed measures: Additional measures you could use:
	Patient experience	Your current proposed measures: Additional measures you could use:
Improve utilisation and sustainability of local health and social care resources	Health and care activity	Your current proposed measures: Additional measures you could use:
	Cost of delivering care	Your current proposed measures: Additional measures you could use:
Improve staff experience	Staff experience and engagement	Your current proposed measures: Additional measures you could use:

► Table 27 Nuffield Trust’s Personalised Advice Template

The benefit of this template is that it insists upon tangible data for supporting what would otherwise be fairly high-level and generalised aims. Modifying this template may provide local interventions with a link to the more abstract aims of the BCT programme as whole.:

Main aims – programme wide	Domain of measurement - pathway specific	Examples of ways to measure this (qualitative or quantitative) – ICC specific
E.g. “Improvement in the quality of care a patient receives.”	Patient Outcomes	...
		...
	Patient Experience	...
		...
Etc.		

► Table 28 Modified Template for Localised Data Collection

There are two caveats to using this as a template for evaluation, however.

- First, the most important point for monitoring ‘ground up’ initiatives is that the reporting is formative; that is, it can feedback to the delivery in a meaningful and regular way to steer the progress of a pathway or intervention. This is one of the main benefits of localised measurements, as they should ideally be more immediately visible (and thus quicker to respond to) than the higher-level aims.
- Second, the success of the measures (be they qualitative, quantitative or mixed) must be open to review and challenge. Measures, like aims, must be falsifiable, which means that the measures chosen must be able to show not only successes, but also lack of success where necessary. For this reason, smaller-scale measures are best decided on through conversations with multiple stakeholders, which may include citizens or patients

Evaluating Clinical Quality Improvement

One of the main outcomes stipulated in the BCT logic model was improved quality of care. While there are obviously many evaluation methods for assessing quality improvement, Shortell et al.⁴⁹ have provided a matrix of quality improvement which details the aspects needed to produce lasting organisation-wide impact. This tool can be useful for identifying how changes introduced are supported by wider aspects of a health system, as well as identifying the key enabling and disabling mechanisms such a change might need to address during planning and delivery. While this is not an evaluation method in itself, it provides a good starting point for locating the kinds of measures which may need to be reported on in order to provide a robust evaluation of system-wide change.

Strategic	x	Cultural	x	Technical	x	Structural	=	Result
0		1		1		1	=	No significant results on anything really important
1		0		1		1	=	Small, temporary effects; no lasting impact
1		1		0		1	=	Frustration and false starts
1		1		1		0	=	Inability to capture the learning and spread it throughout the organisation
1		1		1		1	=	Lasting organisation-wide impact
0 = absent; 1 = fully present								

► Table 29 Shortell et al.’s Dimensions needed to achieve clinical quality improvement

49 Shortell SM, Bennett CL & Byck GR. Assessing the impact of continuous quality improvement on clinical practice: what it will take to accelerate progress. The Milbank Quarterly 1998: 76: 4, pp.593-624

Appendix Six: Outcomes Survey – Key Findings

Introduction

As discussed in Section 2.5, to explore levels of engagement with BCT and understanding of its shared outcomes, staff from three ICCs were invited to complete a survey. The survey was available to complete online for five weeks in September and October 2017. The response rate was very low, with only 13 surveys being completed. Despite these data limitations, analysis of the survey responses still provides some additional and valuable insight into experiences of the ICCs. The key findings emerging from this analysis are presented here.

Engagement with ICCs

All respondents felt that they had engaged with their local ICC at least to some extent, with the level of reported engagement varying across respondents. The survey asked respondents to indicate how engaged they were with their local ICC, where 1 indicated 'not at all' and 5 'very much'. Although six rated it as 2 or 3, no respondent provided a 'not at all' rating and, more positively, seven rated the impact as a 4 or 5. The small number of respondents prevents the identification of patterns and relationships in the data (and respondents worked in only three out of the 12 ICCs which further limits its representativeness), but as would be expected, those with a job role directly linked to BCT (Programme and Project Managers) reported higher levels of engagement. Eight out of the 13 respondents were either a GP or Practice Manager, for them, perceived engagement appeared to reflect their attendance at meetings or involvement in its interventions. For example, one Practice Manager reported that they attended all meetings and had been involved in the piloting of pathways and they therefore felt that they were 'very much' engaged with their local ICC. Only three respondents reporting lower levels of engagement provided additional information to explain their rating, one explained that they had not attended recent meetings, another stated that the ICC's primary focus was on physical health, and a third felt that their involvement was restricted by broader issues.

The impact of the local ICC on respondents' day-to-day work and their delivery of services was also explored in the survey. When asked about the impact on day-to-day work, nine respondents rated it as either 2 or 3 (where 1 is no impact at all) and four provided higher ratings of 4 or 5. Where additional comments were provided (by nine respondents) to explain the impact rating, they were varied with each respondent citing a different factor or issue. For example, a respondent providing an impact rating of 2 stated that although they are invited and encouraged to attend meetings, their involvement requires time out of their practice. Another respondent, also providing a 2 rating, criticised the ICC for being "slow moving and too conceptual on the possibilities whilst lacking in simple achievable goals to drive forward." More positively, those providing a 4 or 5 rating cited various examples of impact on their day-to-day work including the Wellness Hubs, prevention agenda, regular use of the care navigators and case managers, and increased signposting to other services. Fewer respondents thought that their local ICC had had an impact on the delivery of their services, with three stating that it had no impact at all, seven rating it as 2-3, and three as 4-5 (where 5 is a lot of impact).

Closer networking and joined up working were identified as the most important changes to working practices brought about by the ICC (cited by four respondents out of a total of eight answering this question), however, two of these respondents were a Programme or Project Manager. Examples of this type of response included: "closer networking with other services" and "the ICCs have enabled services to integrate and communicate more effectively. Services are becoming joined up and the system approach better understood." Another respondent stated that the ICC had led their team to refocus their work using asset based principles, two stated that it was too early for change and another felt that the ICC had not brought about any changes to their working practices.

The survey also explored perceptions of impact on service users; only one respondent (who did not disclose their job role) stated that there had been a lot of impact, three thought that there had been no impact, and eight rated impact as either 2 or 3 (where 1 is none and 5 is a lot). The respondent stating that there had been a lot of impact thought that the ICC had brought about "greater access to services for patients". One respondent stating that it had not had any impact on service users described how the merger of GP practices had been perceived negatively by patients "comments have included – intrusive and judgemental reception staff, don't know what's happening, unable to see the same doctor, herded through the system, loss of personalised service, increase in cancelled appointments with nurses." Three other respondents (who provided a 1, 2 and 3 impact rating) all commented that services were still in the early stages and others stated that the ICC was "supporting communities to shape their own wellness. Lifestyle and behaviour choices etc." and that care navigators and case managers were supporting complicated cases.

Understanding of ICCs

All but one respondent felt that they had at least some understanding of the aims of their local ICC, with seven stating that they understood them very well and five that they somewhat understood them. However, when asked what its aims were, responses were varied and included reference to the triple aims, co-operative working practices, early intervention, sustainable and accountable health systems, and improved local services.

In terms of their own role and responsibilities within the ICC, five respondents stated that they understood it very well and eight that they somewhat understood it. Two of those respondents reporting high levels of understanding described what could enable help them to better fulfil their role and responsibilities:

Certainty over continuation funding beyond March 2018 and expansion of the ICC offer through Community Services development.

More enthusiasm & co-operation from other practices in the ICC.

Those that somewhat understood their role and responsibilities or had no understanding at all were asked what would improve their understanding, three of whom provided a response. A range of different factors were cited, including: a perception that their responsibility related to supporting and promoting ICC activities only and that protected time away from the day job was needed; that it should be GP centric; and engagement with and input to ICC discussions.

Understanding of the aims of the BCT programme overall were comparable to understanding of the local ICC's aims. Out of the 13 respondents, eight somewhat understood them and five understood them very well. Three of those with higher levels of understanding described the aims and although different descriptions were provided, all referred to increased collaboration and joint working to achieve improved care.

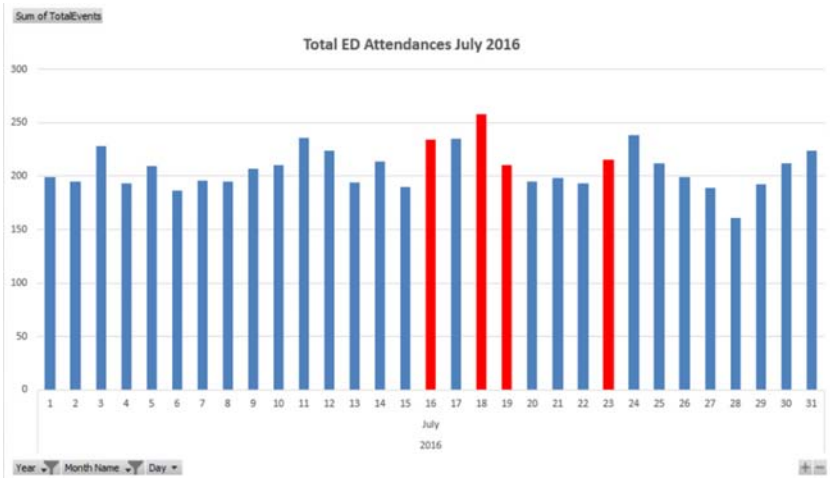
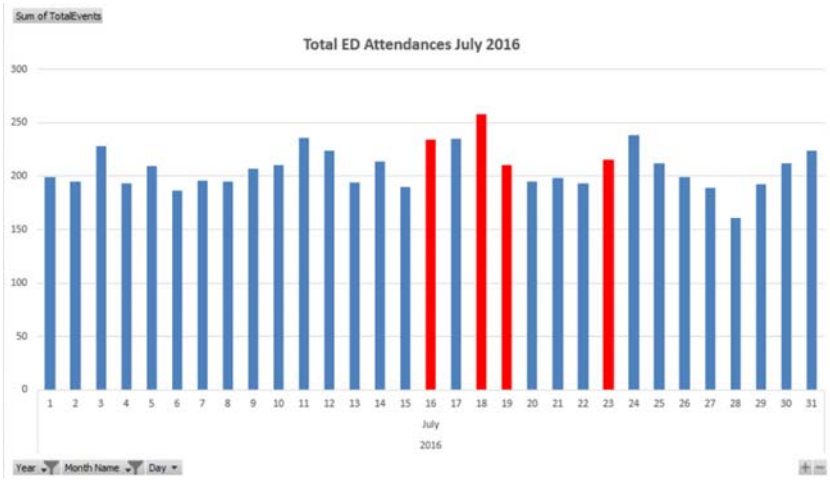
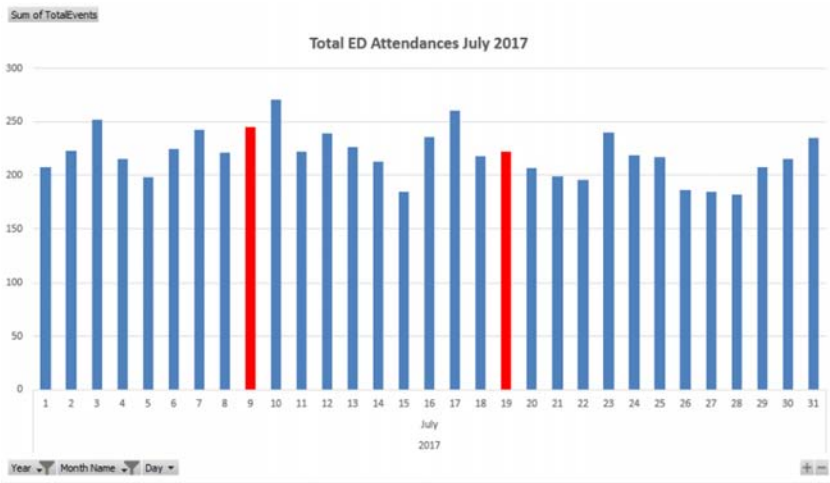
Appendix Seven: Social Media Announcements and ED Attendance

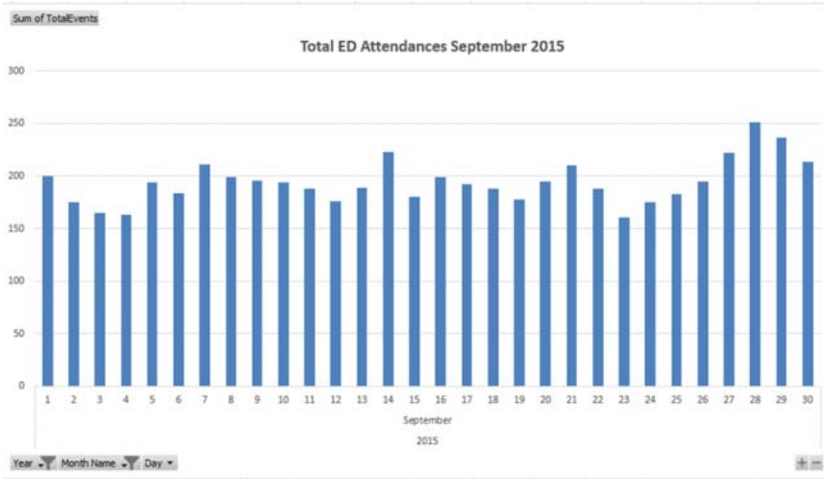
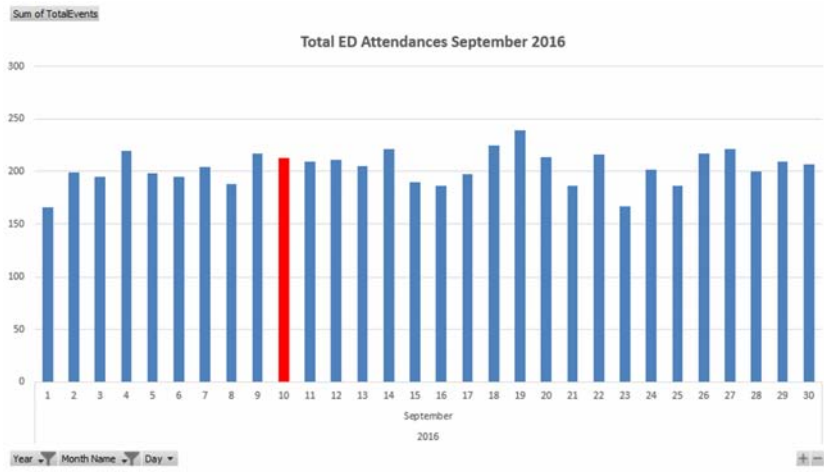
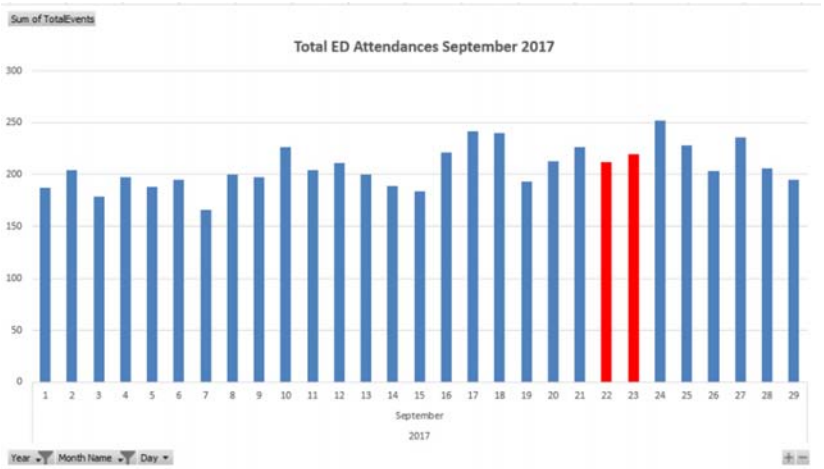
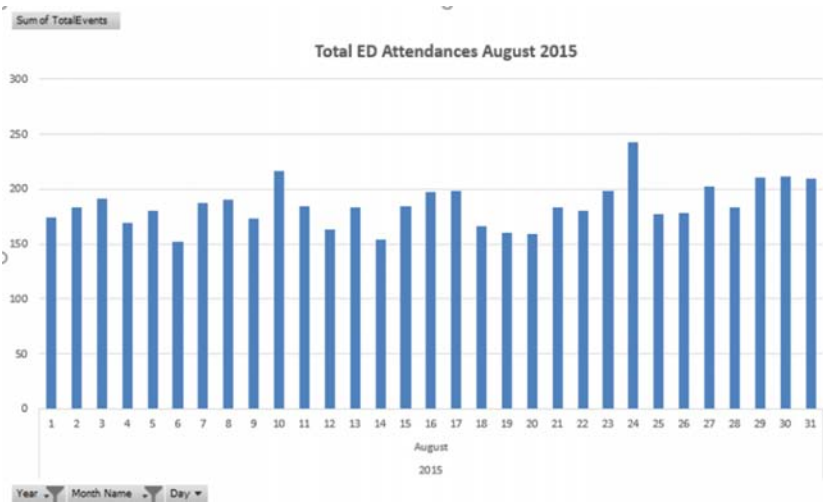
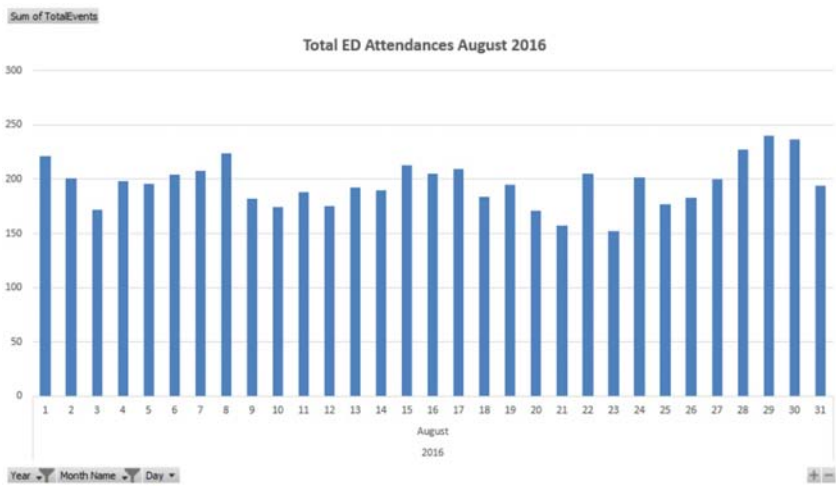
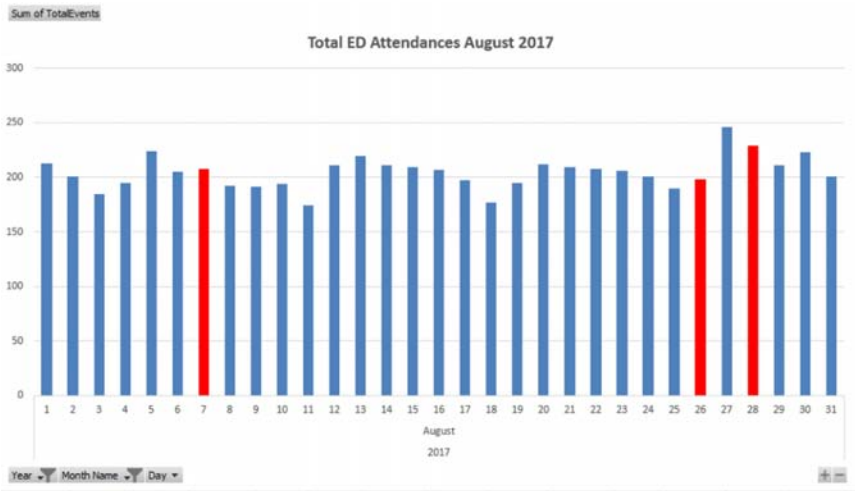
During the course of the vanguard funding, UHMBT used social media on specific days to discourage the public from attending A&E departments. In some cases this was due to serious events (for example, a junior doctor’s strike on 21/04/2016; or following an outbreak of norovirus on 21/12/2016 and 06/01/2017 those with diarrhoea or vomiting were advised to not attend). In others, no specific reason was given. In total, 28 social media messages were distributed between December 2015 and October 2017.

A brief look at three months of ED Attendance across three years (to compare months where announcements were made, to those where there were none) shows no immediate effect on total numbers of attendance. In cases where numbers drop in the days following the announcement, it seems more likely that this is reflecting seasonality (when compared to the same days in previous years).

This remains a high level analysis, however. There may well be other effects that the announcements are producing which are not immediately realisable, and may be complimented by activities taking place within the BCT programme.

The comparative figures are presented below. Days where announcements were made are highlighted in red; days without an announcement coloured blue.





► Figure 71 Comparison of ED Attendances in relation to social media announcements

